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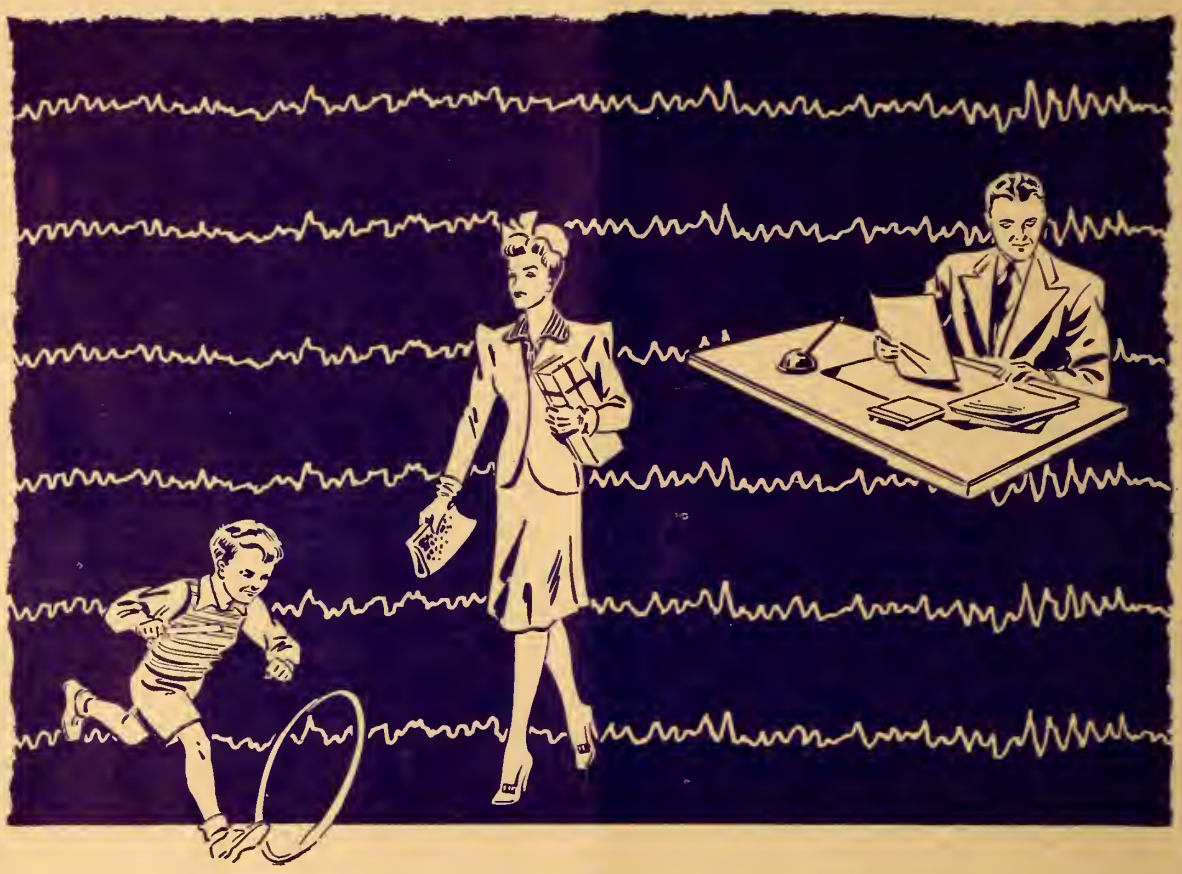
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Executive Secretary—John Hunton, 450 Sutter Street, Room 2004, San Francisco.

General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco.

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(Continued on Page 5)

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2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, Floyd A. Burger, Box 193, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. Headen Inman, 501 Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
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Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2212 W. 3rd Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard. Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, Edward A. Macklin, P. O. Box 176, Kelseyville.
Secretary, John H. Lloyd, Fort Bragg.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Winton F. Swengel, 499 Pacific Street, Monterey.
Secretary, Arnold Manor, 578 Polk Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

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President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

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Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street. Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Deon A. Crew, 748 Marsh Street, San Luis Obispo.
Secretary, Joseph G. Middleton, 1130 Garden Street, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie, 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, R. L. Zieber, 833 Fourth Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
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Meeting, *At Call of President.*

Tulare County Medical Society
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Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
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Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
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Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
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(Continued from Page 3)

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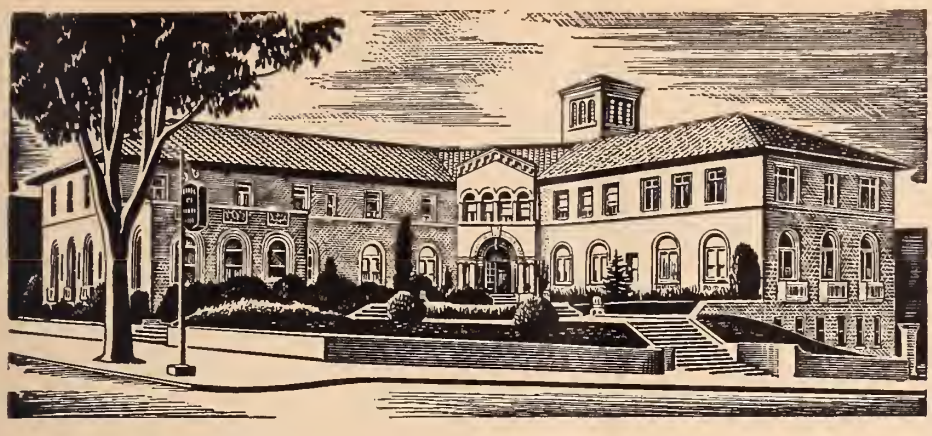
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BOOKS RECEIVED

The Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M. D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Pp. 424. Price $3.00. Chicago: The Year Book Publishers, Incorporated, 1942.

The Art of Seeing. By Aldous Huxley. Cloth. Price $2.50. Pp. 273. New York and London: Harper & Brothers Publishers, 1942.

BOOK REVIEWS

The Art of Seeing. By Aldous Huxley. Cloth. Price $2.50. Pp. 273. New York and London: Harper and Brothers, Publishers, 1942.

Aldous Huxley walks through the scientific looking-glass and pictures from his pseudoscopic view the phantasmagoria created by Bates in 1920, in which all the accumulated knowledge of physiologic optics is scrapped, and cause and effect reversed in the seeing mechanism. According to these occultists, "Mal-functioning produces . . . errors of refraction." . . . "There is nothing inevitable or predestined about the long sight of old age." . . . "When people have learnt the art of seeing and conscientiously follow its simple rules, their eyes, if these are diseased, tend to get better. . . . Experience shows that this is what in effect generally occurs when persons, suffering from such conditions as glaucoma, cataract, iritis, detachment of the retina, learn how to use their eyes and minds properly instead of improperly." Also "10 to 15 per cent of the population cannot work under fluorescent light without suffering from bloodshot eyes, swollen eyelids and lowered vision."

(Continued on Page 10)

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The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.



A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Excercise . . . helpeth to restore the crooked Bones. . . ."

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SWADDLING was practised down through the centuries, from Biblical times to Glisson's day, in the vain hope that it would prevent the deformities of rickets. Even in sunny Italy swaddling was a prevailing custom, recommended by that early pediatrician, Soranus of Ephesus, who discoursed on "Why the Majority of Roman Children are Distorted."

"This is observed to happen more in the neighborhood of Rome than in other places," he wrote. "If no one oversees the infant's movements, his limbs do in the generality of cases become twisted. . . . Hence, when he first begins to sit he must be propped by swathings of bandages. . . ." Hundreds of years later swaddling was still prevalent in Italy, as attested by the sculptures of the della Robbias and their contemporaries. For infants who were strong Glisson suggested placing "Leaden Shooes" on their feet and suspending them with swaddling bands in mid-air.

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BOOK REVIEWS

(Continued from Page 7)

Why are literati so captivated by charlatans and pseudo-science? How does the son of a famous scientist come to write such a book? These are problems for the psychoanalyst. In Aldous Huxley's case the eye consciousness, which most writers have, was aggravated by an ocular disease at age 16 which left both eyes with corneal opacities. In 1939 he "found the task of reading increasingly difficult and fatiguing" and decided to explore the Bates "method of visual re-education," from which he claims subjective benefit, though admitting that his vision is still far from normal.

The basic idea of the Bates system is that the organs of vision are capable of curing themselves without the aid of "artificial lenses" either in childhood or later life, and whether affected by amblyopia, myopia, astigmatism, hyperopia, squint, or presbyopia. The perfect retort to this wishful thinking is this sentence from Huxley, which he uses in another connection with much less relevance: "This is not true; but the belief that it is true can cause a great deal of harm to those who entertain it."

The "eye exercises," described in minute detail, are simple (in every sense of the word), and consist of drills in palming, sunning, flashing, and shifting of attention. The use of the imagination is stressed—and well it might be!

Quoted in the Appendix is a clear scientific exposé of the false assumptions of the Bates method, published by Dr. Arnold Sorsby, in the *British Medical Journal*. Huxley's specious and sophistical comment thereon is a remarkable commentary in itself on his own attitude and state of mind. J. E. L.

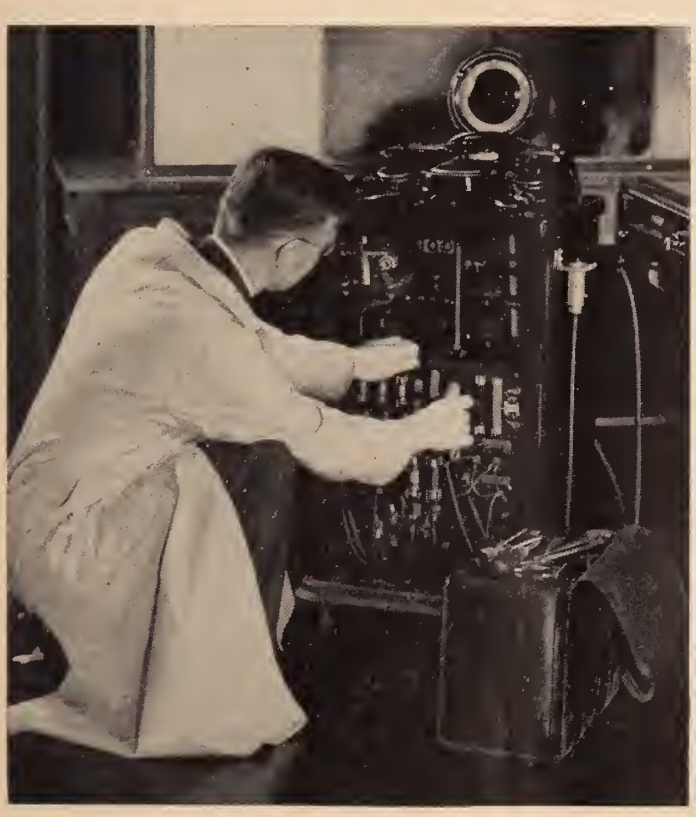
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Sectarian Practitioners and Social Security Act Programs.— The following excerpt is from the report of the House Committee on Appropriations on H. R. 7181, the Department of Labor, Federal Security Agency, and Related Independent Offices Appropriation Bill, Fiscal Year 1943:

"In its report on the appropriations bill for 1942, the committee included the following statement:

'It has come to the attention of the committee that under the authority of the Bureau to pass upon State plans for grants-in-aid pursuant to the provisions of the Social Security Act certain standards have been adopted by the Bureau regarding medical care that have the effect of disqualifying certain groups of health practitioners that do not possess a degree in medicine from a recognized medical school, even though they have had educational training in medical and health subjects to an equal degree with the medical group. The committee is unable to endorse the wisdom of such a policy of exclusion and suggests that the Director of the Children's Bureau reopen this question with a view of giving proper accreditment to any such group so discriminated against.'

"The committee is advised that no action has been taken looking toward compliance with this suggestion. The position of the Bureau is such as to forbid the use by beneficiaries of the various grants of practitioners of healing-arts recognized in State law and to grant an absolute monopoly to one group as opposed to another. In view of the fact that no consideration has been given to the suggestion contained in the report of a year ago, the committee desires again to call attention to the matter and to request emphatically that the responsible officials of the Department of Labor give immediate and objective consideration to the proposal." (House Report No. 2200, 77th Congress.)

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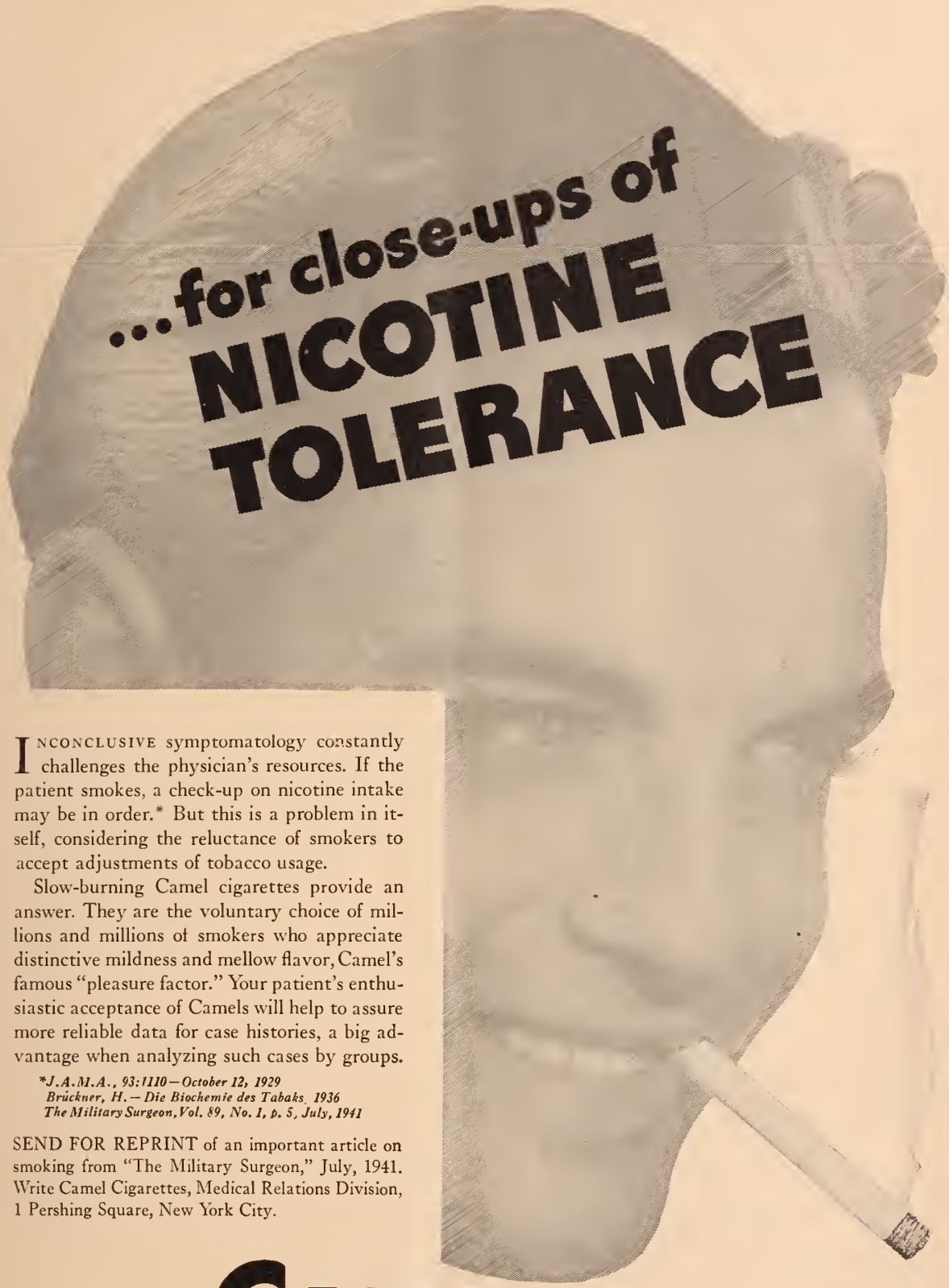
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*J.A.M.A., 93:1110—October 12, 1929
Brückner, H.—Die Biochemie des Tabaks. 1936
The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

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BOOK REVIEWS

(Continued from Page 10)

Fractures. By Paul B. Magnuson, M.D., F.A.C.S., Associate Professor of Surgery, Northwestern University Medical School, Attending Surgeon, Passavant Memorial Hospital and Wesley Memorial Hospital, Chicago. Cloth. Price $5.50. Pp. 511, with 317 illustrations. Fourth edition revised. Philadelphia, Montreal, London: J. B. Lippincott Company, 1942.

Fourth edition of this excellent work represents a thorough revision. Many new illustrations appear and valuable suggestions abound, especially those dealing with the rôle the medical profession must play in the present global war in the handling of compound fractures. Emphasis is again placed on the importance of considering each fracture as an individual case and treating it as such. The bibliography is adequate, the index complete and the book well edited and printed. It is a valuable addition to the texts on the subject and will make a welcome addition not only to the library of the medical student but to the working library of the surgeon as well.

Shock: Its Dynamics, Occurrence and Management. By Virgil H. Moon, A.B., M.Sc., M.D., Professor of Pathology, Jefferson Medical College, Philadelphia, Pa. Cloth. Price $4.50. Pp. 324. Illustrated with 36 engravings. Philadelphia: Lea and Febiger, 1942.

A condensed practical treatise on the phenoma of shock containing new information on the diagnosis and treatment of this condition.

The first part of the work deals with the physiological and pathological features of shock. The importance of the capillaries in the economy of the body is first emphasized, following which the characteristic features of and theories concerning shock are well stated. Points of similarity and contrast between shock and the effects of hemorrhage are stressed, the author stating that for the sake of accuracy, the expression *shock and hemorrhage* should be substituted for the term *hemorrhagic shock.*

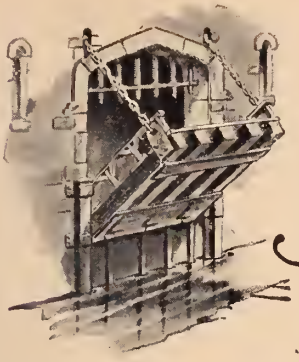
The second part deals with the prevention, recognition, and management of shock. An excellent section on the recent developments in the preparation of blood substitutes and their use precedes the adequate list of references. The short summary which concludes each chapter is of value especially to the busy physician. The book is timely and should appeal to general practitioner and specialist alike.

Essentials of Pathology. By Lawrence W. Smith, M.D., Professor of Pathology, Temple University School of Medicine, and Edwin S. Gault, M.D., Associate Professor of Pathology, Temple University School of Medicine, with a Foreword by James Ewing, M.D., Memorial Hospital, New York City. Second edition. Cloth. Price $10.00 Pp. 904, with 679 illustrations and 295 illustrative cases. New York: D. Appleton-Century Company, Inc., 1942.

The older concept of pathology was that of a science which considered the results of disease mainly structural and paid little attention to attempting to explain any of the clinical features. A pathologic classification was often entirely different from a clinical grouping, and could only be determined by the result of an autopsy. In recent years the emphasis has shifted. Pathology now uses morphology as an index of functional changes, and a valid classification should now make clinical manifestations of disease indicate the anatomic changes present. Modern tests of pathology strive to furnish the background and basis of clinical medicine.

Smith and Gault, in this text (revised since its first appearance four years ago), have attempted to correlate the basic philosophy of disease with clinical medicine by

(Continued on Page 16)



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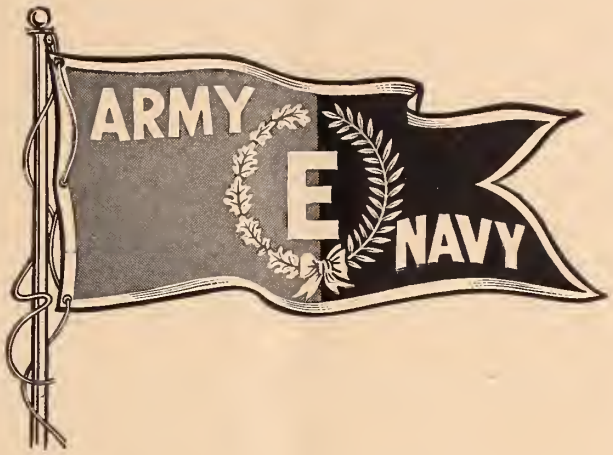
the use of almost three hundred case reports interpreted by the gross and microscopic changes. By this device the abstract facts are vitalized and applied to the problem confronting every physician—how are the symptoms, signs and prognosis of the sick patient related to changes in his cells, tissues and organs?

Even a casual acquaintance with medical meetings reveals that the art of abstracting a medical history is widely and successfully neglected. Excellent models in grammatical brevity and clarity may be found in the case reports analyzed in the text. The histopathology is well given by almost 700 illustrations which are gathered in plates, the large format permitting four to six adequate cuts on each page.

To give the necessary space to the case histories, the text has been limited, as the title implies, to essential and fundamental principles. The increasing importance of parasitic diseases and of tumors is acknowledged by the allotment of more than the usual proportion of space to these subjects. In places, this brevity has resulted, perhaps, in too much elimination of shades of opinion, although, on the whole, much information is condensed in the brief paragraphs.

Such a concise text is obviously not suited for encyclopedic reference or for detailed information about unusual conditions. It is exceptionally well suited, however, for its planned goal: to furnish a practical basis for the student to interpret clinical medicine. While the volume was lying on the reviewer's desk in the laboratory of a general hospital, it was interesting to observe the house officers, first glance at it, then leaf it casually, and finally settle to a fascinating hour of painless study.

(Continued on Page 18)



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BOOK REVIEWS

(Continued from Page 16)

It is also adapted for those of us who, while past our formal student days, feel the utility of a review of the fundamental reactions of the body to disease. It can be recommended as an eminently readable volume for the clinician to refresh his interest in the relations between the basic changes of disease and the clinical problems which are his daily bread.

JAMES DAY EDGAR, M. D.

When Doctors Are Rationed. By Dwight Anderson, Director Public Relations, Medical Society of the State of New York, and Margaret Baylous, Therapist, Charleston General Hospital, Charleston, West Virginia. Cloth. Pp. 255. Price $2.00. New York City: Coward-McCann, Inc., 1942.

Among constituent state medical societies, few have more active public relations departments than the Medical Society of the State of New York. Its director is Dwight Anderson, the author of the present volume. Nathan B. Van Etten, former speaker of the House of Delegates and ex-president of the American Medical Association, has seen fit to write the introduction for this volume, which participation may be taken as an index of its worth. Attention is called to the fact that food and warmth, transportation, rubber, gasoline, oil, and metals are already subject to the necessity of careful distribution. Family life is dislocated; seven million young American men are being assembled into fighting forces. Forty-five thousand physicians are being transformed into soldiers or sailors. Nearly one-third of the active practitioners of medicine are being taken away from their accustomed service to their communities; many communities will be deprived of their usual faci'i-

(Continued on Page 20)



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BOOK REVIEWS

(Continued from Page 18)

ties for medical care. Small towns have mushroomed into large cities because of expanding war plants, and must be supplied with medical care. Towns and cities have lost their young physicians and must be served, so doctors must be rationed. Hospitals must be restaffed by older physicians, nursing service must be immensely enlarged; necessity demands total enlistment in a total war.

Revaluation of medical services and facilities must be worked out in great detail. The authors of this book have analyzed available and prospective medical resources; they have studied the problem for many years, and are providing here the first book to bring an accurate interpretation of medical service to the attention of the public.

As early as September, 1939, the American Medical Association offered all of its organizational facilities to the government of the United States. This coöperation was requested by the Surgeon General of the Army in June, 1940, and a committee on preparedness immediately began to function providing the government with a personal-history file of every physician in the United States which was started many years ago and contained the details of his life from high school to date.

Ready for the use of the government was a classification of every hospital bed in the United States, one million three hundred thousand of them. Also a complete record of every medical school and every medical student and hospital intern was open for immediate reference.

Civilians must derive a great deal of comfort from the knowledge this book provides that their sons in the fighting forces are served by the most competent physicians in the country who know the advances of medicine better than the average of older physicians. Readers will be heartened by the knowledge of the quality of medical education, medical personnel, and hospital facilities upon which they must depend for basic care at their homes and for emergency defense.

The table of contents of the volume indicate the logical distribution of topics that are discussed in detail, the same including such subjects as the following: Will Rationing Affect You?; The Mechanics of Rationing; Medical Needs for Civilian Defense; Soldiers and Sailors to Get the Best; Public Health Comes to Your Door; Doctors for Boom Towns; Women Doctors in Wartime; How to Avoid Fakes and Quacks; The Output of Medical Schools; What Medical Societies Can Do for You; There Will Still Be Specialists; When You Go to the Hospital: "Bedside Manner" During the War; Will "Home Remedies" Return?; How to Be a Good Patient; What We Expect of Doctors; How to Choose a Doctor.

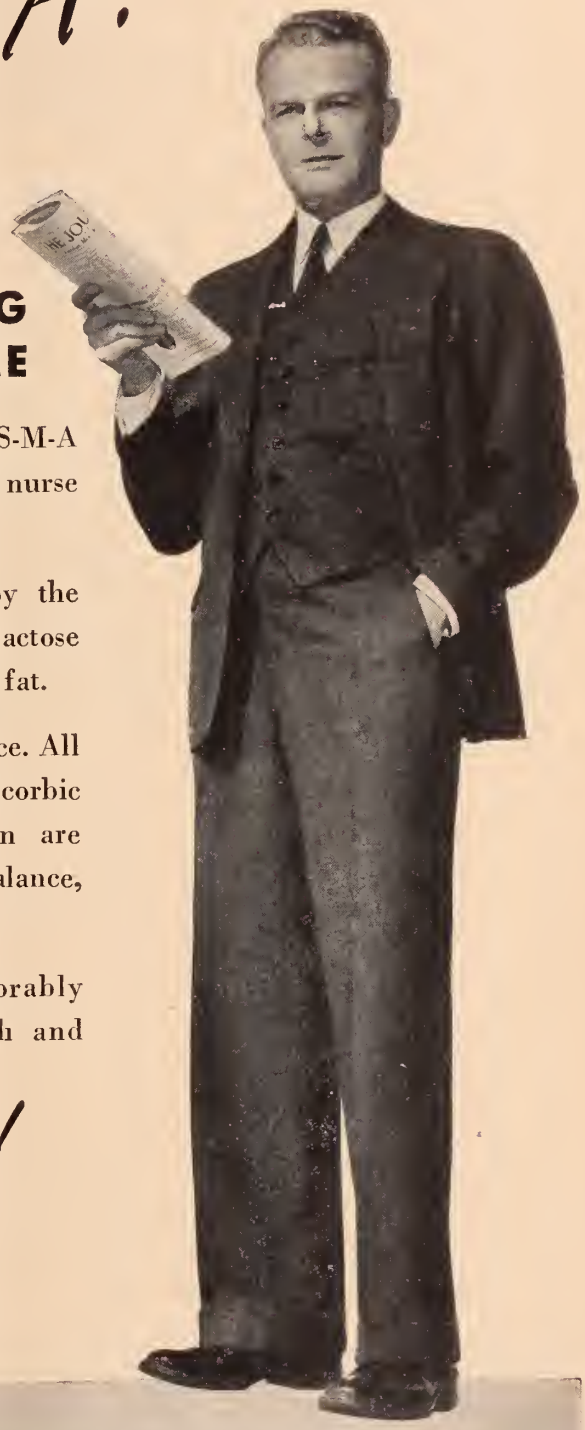
Food Charts: Foods as Sources of the Dietary Essentials. Prepared by a joint Committee of the Council on Foods and Nutrition of the American Medical Association and of the Food and Nutrition Board of the National Research Council. Paper. Price 10 cents.* Pp. 20. American Medical Association, Chicago, 1942.

* Quantity prices on request.

Current interest in nutrition is at a high level and the subject merits all the attention which it is receiving. Information about the composition of foods now is on a quantitive basis. A forceful presentation of some facts about foods as sources of the dietary essentials is provided by the present illustrated essay, which has been prepared by a joint committee of the Council on Foods and Nutrition of the American Medical Association and of the Food and Nutrition Board of the National Research Council. There are eight charts showing the

(Continued in Back Advertising Section, Page 24)

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EDITOR GEORGE H. KRESS

Committee on Publications

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F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

RECENT MEETING OF PACIFIC STATES PROCUREMENT AND ASSIGNMENT SERVICE COMMITTEEMEN

Session of National, State and Local Procurement Officers.—Commencing Tuesday, January 12th, an important session of Procurement and Assignment Service committeemen of the ninth army corps area and the 11th and 12th naval districts, representing the professions of medicine, dentistry and veterinary medicine, met at the Sir Francis Drake Hotel in San Francisco, to confer with the representatives of the Washington office of the Procurement and Assignment Service of the War Manpower Commission (Doctors Harold S. Diehl and Max E. Lapham), and consider procurement problems that have arisen in the areas mentioned.

Only those members of the medical profession who have had responsibilities in this work can appreciate the many worries that have beset state and local procurement representatives, as succeeding directives from headquarters at Washington, D. C., modified or nullified prior instructions. Since the judgments of state and local procurement committees, in relation to decisions on whether individual physicians, should or should not apply for commissions with the Armed Forces, may have good or ill influence on the future careers of many physicians, it is only natural that the procurement committeemen should desire explicit instructions that can be carried out in impartial and impersonal manner.

It is not possible to give a transcript of the many phases of procurement work which received comment or discussion. As the meeting progressed, the impression early became evident that all the committeemen in attendance were earnest in their desire to do everything within their power, in order to provide medical personnel in quality and number that would make possible, adequate medical care for all citizens, not only for those attached to the Armed Forces but also to those who have civilian status.

* * *

Some of the Information Brought out in the Meeting.—Without further comment, note is made in the following paragraphs of some of the statements by various speakers, with special reference to our California problems. As new instructions are received, the State procurement officers and their local committeemen probably

will be in position to amplify or clarify some of the following announcements:

The establishment of state quotas was not an easy matter. The political-geographical units were deemed best to follow, rather than trade or community areas, even though, in special instances, the latter might have provided a more accurate background concerning medical needs.

Looking backward, it is a question whether the recruiting teams of the Army, which were established in some of the States, were a real asset in the work. So much depended upon the tact and efficiency of the medical officers in charge. The recruiting teams have been discontinued in all but five states, and it is planned to give up that service altogether.

The medical departments of the Army and Navy are relying more and more upon the recommendations of the State Procurement and Assignment officers. So much so, no physician will be given a commission unless certified to as available by the proper Procurement Board.

Procurement and Assignment service, for the time being, will be limited to 21 states; the other commonwealths, up to the present time, having filled their quotas.

The heavy enrollment of medical officers during the year 1942, greatly depleted the pool of available physicians, for present and immediate future needs.

The A.M.A. roster of 1941, based on its questionnaire of that time, indicated that 176,000 physicians were in active practice in the United States. Certain deductions were necessary to secure a figure that would represent a more accurate pool of medical men who could be utilized to supply needs of the Nation for medical services. Deductions included such items as: loss through death; full-time employees of state and local health departments; hospital administrators; teachers in medical schools; hospital residents; ineligibility because of physical disabilities; efficiency deductions as higher age brackets were reached.

When all deductions were made, it appeared that the total pool of physicians available for military service and civilian practice, on October 1, 1942, approximated 136,000, instead of 176,000.

In the Armed Services, up to November 1, 1942, the enrollment of physicians in the Medical Corps of Army and Navy was 40,945.

With quotas based on the proportion of one physician to 1,500 citizens—the figure used as a base in the calculations—it was found that after deductions had been made, the total number of physicians who could be construed to be available for military service was 52,400, of which number 40,945 had been enrolled up to November 1, 1942; thus leaving a total of 11,455 Doctors of Medicine still available for all branches of the Armed Forces.

The tables of organization for medical officers, as established by the Army and Navy, are construed to be the ideal ratios. It is held that these ideal tables should stand, even though the Surgeon Generals may find it necessary to make modifications or adjustments, in view of the limited number of physicians still available. Thus, while under the ideal tables a total of some 30,000 additional enrollments of physicians might be needed for the Armed Forces, the military authorities will reduce that figure to some 11,000. in order that civilian needs for medical services shall also be met. In other words, at the present time, both the Armed Forces and the civilian population will be obliged to accommodate themselves to a lesser number of physicians than those indicated in the accepted tables, and to the overall ratio of about one physician to 1,500 persons.

The Army and Navy have come to a mutual understanding concerning the proportion each service will take from the pool of 11,455 physicians who are construed at the present time to be available for military service.

Procurement and Assignment officials at Washington hope the 1943 recruitments will be made prior to November 1st, preferably in monthly allotments, to permit the Washington authorities to make proper tabulations for the calendar year.

The California quota, from December 1, 1942 to the end of 1943, is estimated as 1,139 physicians still to be enrolled. It is estimated that these physicians should come approximately from the following districts: Bay Region (San Francisco, Alameda, Contra Costa and Solano Counties), 345 physicians; Los Angeles (Los Angeles and Orange Counties), 761 physicians; remainder of California, 33 physicians.

It was stated that if a physician, construed to be essential in industry or civilian practice, left such a place of his own volition, to take up practice in some other community, it would be proper to certify him, in his new location, as being available for military service.

The problem, of who and how many physicians should be declared essential in certain war industries, is now a subject of earnest study.

On December 1, 1942, California was credited with a total enrollment of 2,266 physicians enrolled in the Armed Forces.

CALIFORNIA'S MEDICAL PRACTICE ACT—ARE TEMPORARY LICENSES TO PRACTICE DESIRABLE?

Early Correspondence.—On September 26th last, the C.M.A. Council, through its chairman, Captain Philip K. Gilman, took up with the California State Council of Defense, special consideration of the presumable "shortage of trained medical aid."

If a "doctor shortage" does exist in the State, the California Medical Association, through its constituted officers, wishes to take steps necessary to provide adequate medical care for citizens. Council Chairman Gilman's letter of September 26, 1942, outlines the problem, and for the information of C.M.A. members, appears below.

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

September 26, 1942

Sub-Committee on Health of
Emergency Medical Service,
California State Council of Defense,
Bertram P. Brown, M. D., Chief,
995 Market Street,
San Francisco, California.

Dear Sirs:

Your letter of September 25th, relating to "shortage of trained medical aid," has come to hand.

I am sending copies of your letter to the members of the C.M.A. Council with request for suggestions, and in due course will again write you.

In the meantime, may we ask you to send us such information as may be available from the files to which you have access, concerning the districts or communities in California where a shortage of medical personnel is now in evidence, and to what extent?

We all appreciate the increased work on physicians remaining in civilian practice, but they carry these increased burdens as part of their contribution in the existing emergencies.

How would you determine the fitness of medical graduates of foreign countries? (The California Board of Medical Examiners has shown that a considerable number of such foreign M. D.'s present false or misleading statements concerning former training.) . . .

If a grave emergency were to arise, and medical aid was rendered by unlicensed physicians, is it not more than possible that the State Board of Medical Examiners would take no notice or action concerning such violation of the law, looking upon the same as a pardonable technicality?

As stated in your letter, the present and future complications involved in temporary licensure are of a serious nature. It has taken almost a century of effort to bring standards of medical practice in California to their present status. It would be a real detriment to public health interests, if the existing standards were temporarily nullified, with future possibility of permanent influx of a large group of poorly trained physicians.

May I hope to hear from you in regard to the above?

Cordially yours.

PHILIP K. GILMAN, M. D.,
Chairman, C.M.A. Council.

Without going into details, it may be stated that other correspondence followed; and special study was given to the subject by the C.M.A. Committee on Public Policy and Legislation.

* * *

Proposals of the "Federation of State Licensing Boards."—Under date of December 10, 1942, a communication was received from Secretary Walter L. Bierring of the Federation of State Medical Boards, with which was enclosed "proposed legislation to authorize and provide for the temporary admission to practice in your state of physicians and dentists to protect the health of the civilian population during the war emergency period."

Also enclosed was a "statement of principles suggested as a means by which this relocation of physicians and dentists can be done."

The proposed law (Item A) and the statement of principles (Item B) appear elsewhere in this issue. (See page 36.)

In connection with the foregoing, space is also given to two other items bearing on the subject of modification of existing California statutes concerning medical practice. Of these, Item C (on page 37) enumerates some questions which would arise and be worthy of consideration when proposed amendments to the medical practice act are considered.

The comments having the caption Item D (on page 37) deal directly with the provisions outlined in the amendment (Item A), suggested by the Federation.

Because the subject of medical licensure standards is one in which every Doctor of Medicine who is licensed in California has an inherent interest, attention is here called to the above.

Component county societies and members who are interested are requested to communicate their views, on whether California's Medical Practice Act should be amended to provide for temporary licenses, to the Council of the California Medical Association, Doctor Philip K. Gilman. Chairman, 450 Suttter, San Francisco.

MEDICAL PUBLICATIONS FOR HOSPITAL STATIONS OF MILITARY CAMPS IN CALIFORNIA

Medical Libraries have given Generous Cooperation.—Notices containing requests for medical publications (journals and books) for distribution to hospital stations of military camps in California, have been given editorial and other comment in recent issues of CALIFORNIA AND WSTERN MEDICINE. The response thereto was not as large as had been expected, but journals, in considerable number, were received by the three medical libraries of California (Stanford, University of California, Los Angeles County Medical Association, and by the C.M.A. office). In addition, the three medical libraries made available from their shelves, a large number of duplicate volumes and these, with the journals, were shipped c/o Medical Officers in Command, to the hospital stations of many of the rather large number of Army and Air Force camps that are now located in California. Because the Navy stations are closely grouped and adjacent to the larger cities, where good library facilities are available, it was not deemed necessary to forward the publications to the hospital stations of that service.

Of course, the books and journals were not the latest editions or issues. However, since only sparse literature is available at some of the recently organized camps, it was felt that even such was better, than few or no medical publications.

From time to time, as material comes to hand, other shipments will go forward. The Postgraduate Committee has also voted to charge against its budget, the cost of sending CALIFORNIA AND WESTERN MEDICINE to all California camps, and if satisfactory arrangements can be made, to subscribe, in addition, to certain other publications to be sent to some of the hospital stations.

Military Colleagues are Appreciative.—Colleagues in the military service have expressed their appreciation of the effort to supply medical literature to their camps. Two copies of reply letters received are appended:

———— Training Detachment
Office of the Surgeon
————, California
January 3, 1943.

Subject: *Receipt of Medical Literature.*
To: *California Medical Association.*

1. This office is gratefully in receipt of the medical shipment, reference No. 17, dated December 22, 1942, sent by the C.M.A. Postgraduate Committee.

2. I cannot overemphasize our appreciation of the medical literature you have forwarded this office. The assistant surgeons and I, as well as some of the enlisted men have already begun poring over their contents. All I can say is that this gesture is very fine. . . .

Sincerely yours,
(Signed) ————,
Captain, Medical Corps,
Surgeon.

* * *

Station Hospital
————, California
January 4, 1943.

To: *California Medical Association.*
Gentlemen:

On behalf of the Medical Officers stationed at this hospital, I wish to extend to you our sincere appreciation of your effort to develop the medical libraries in the station hospitals. A packet of medical journals has just been received by us and our thanks are extended to you.

Please be assured that your efforts in our behalf are greatly appreciated.

Sincerely,
(Signed) ————,
Major, M.C.,
Surgeon.

SAVE YOUR HEALTH AND YOUR DOCTOR'S TIME

Excellent Leaflet of the Medical Society of the County of Westchester, New York.—Under the caption, "Save Your Health and Your Doctor's Time," physicians of White Plains and other communities in the County of Westchester, New York, have distributed to their patients a small and interesting leaflet, of size to fit into envelops with statements or other correspondence.

As the months go by, more and more articles are appearing in the lay press, in which the supposed "doctor shortage" is being emphasized—a topic that provides a good slogan for certain proponents of governmental medical care plans who are using it to carry on an educational propaganda in favor of their schemes and obsessions.

* * *

Implications in the Changing Practice.—By now, it is of course evident to all that, to transfer within the short space of a single year, more than 40,000 Doctors of Medicine from civilian practice into the ranks of the Armed Forces (with additional accretions to be made in 1943, until, as stated on another page, the total will swell to 52,400 physicians in military service), could not do otherwise than make for some dislocations in the type of service now available to civilians.

On the other hand, the fact that it has been possible to take so massive a number of physicians from civil practice, without extensive and widespread hardships in medical service being evident, is in itself one of the best refutations to those who, during the last decade, have been shouting themselves hoarse concerning "inadequate medical care."

For the information of C.M.A. members, it may be stated that reports are now being received from component county units of the California Medical Association concerning medical needs in their respective communities, the replies indicating, to date, that citizens of California are still receiving good medical care. More, concerning this, in a later issue.

True it is that, almost everywhere, members of the medical profession are working harder and longer than in former years, but the burden in most places has not been greater than the practicing physicians, themselves, have been willing to bear.

* * *

Merit of the Westchester Educational Leaflet.—Which brings us back to the educational leaflet that has been distributed by the physicians of Westchester County. Our New York colleagues have appreciated early that, under existing circumstances, medical service is a two-way proposition, requiring not only willingness on the part of the physicians to give good service, but coöperation on the part of citizens, to aid in the conservation of the health and time of their medical advisors.

The leaflet tells its story in simple and appealing manner. It is given space below, because of its suggestive value. It is possible that some of the component county societies in California may wish to print similar statements, and to furnish supplies to their members for distribution to patients. The Westchester leaflet follows:

(copy)

Save Your Health and Your Doctor's Time

Rationed Gas, Rationed Tires, Rationed Doctors!

A large proportion of Westchester's physicians have entered military service. Many more are preparing to go. Those left behind, with a few exceptions, are beyond military age, or have some physical disability which has disqualified them for active military duty. Yet these "home front" physicians are being required to carry a greatly increasing burden of work.

You and your family can help both to lighten this burden and to make sure that everyone will get the utmost benefit and safety from the limited medical service that will be available. Here's how:

1. Instead of asking the doctor to come to your home, go to his office when you can.

2. If a house visit is necessary, call the doctor before 8:30 in the morning or before 12:30 at noon, so he can plan his house calls efficiently. A morning temperature is usually followed by a higher one in the afternoon.

3. Don't neglect to inform your doctor of the early signs of sickness. A timely visit to your doctor may prevent serious illness, numerous house calls—even hospitalization.

4. Whenever possible, leave the message with the doctor's secretary. Don't call him personally to the phone unless it is really necessary.

5. Be patient with your doctor if you have to wait in his office, or if he does not respond at once to your call. Remember that he is caring for many more patients than formerly, and he has only twenty-four hours in his day.

You and your neighbors on the "home front" won't suffer from lack of adequate medical care, if we will all help the doctors carry their burden of extra service.

Medical Society of the County of Westchester

EDITORIAL COMMENT†

IMMUNOPOTENTIATING SEX-HORMONES

Clinicians have repeatedly reported a significant increase in natural or acquired antibody titer toward the end of pregnancy, suggesting a relationship between sex-hormones and specific immunity. Attempts to confirm this suggestion, however, have led to conflicting experimental evidence. Dingle,[1] for example, found that in rabbits administration of crystalline theelin produces no significant change in antibody titer; Weinstein,[2] in contrast, was able to demonstrate distinct increases in agglutinins and hemolysins following similar administration. A possible explanation of these discrepancies is suggested by Weinstein's studies of the effects of varying doses of sex-hormones on anthrax resistance, in mice, large doses and small doses often producing contrary results. The results also varied with different time intervals between hormone administration and the subsequent immunity test.

A detailed reëxamination of experimental evidence was therefore undertaken by von Haam[3] and his coworkers of the Department of Pathology, Ohio State University. 1200 carefully selected mice were tested in groups of 10 males or 10 females with an equal number of normal controls, a highly virulent strain of type I pneumococcus being selected as the test organism. Their routine test dose consisted of 0.2 cc. of an 18-hour broth culture injected subcutaneously. With this routine dose all of their control mice died within 26 and 36 hours after infection. Among the hormones tested were: (a) estrone, isolated from pregnant mare urine, (b) progesterone and (c) testosterone propionate prepared by the methods of Ruzicka and Kagi, and (d) stilbestrol, a synthetic estrogenic substance. Each hormone was dissolved in sesame oil (1 mg. per cc.), and was administered intraperitoneally, either as a single dose or as a divided dose given 3 times weekly over a period of from 2 to 8 weeks. Control animals were injected with similar doses of pure sesame oil. The effect of each hormone upon the course of experimental pneumococcus infection was determined by comparing the average life span and number of survivors to the infected in the control and sex-hormone treated groups.

In a typical test, a group of 10 male, and 10 female mice were given six injections each of varying doses of estrone over a period of 2 weeks. Each animal, together with a normal control, was then given the routine multilethal test dose of Type I pneumococci. All nontreated controls died between the 25th and 32nd hour. A distinct protective action was noted in mice given estrone doses ranging between 0.06 and 1.2 mg., nearly 33 per cent of the animals so treated surviving the infection. Death was delayed in the other 66 per cent to from 60 to 80 hours. Mice treated with smaller estrone doses showed less protection, while those given excessive doses (e.g., 2.4 mg.) showed deleterious effects, all hyperestronized animals dying within 23 hours. Similar though less pronounced effects were demonstrated with single doses (0.5 and 1.2 mg.) given 3 to 7 days before the test infection. If given only 1 day before infection the single dose was ineffective.

Parallel tests with progesterone and stilbestrol, showed no protective action. Testosterone propionate, however, protected both male and female mice to a moderate degree if given at a dose level of 0.001 to 0.1 mg. With higher doses, however, the protective effect was increased with male mice, but decreased resistance was noted with females.

In order to determine the probable mechanism of this favorable effect of sex-hormones a study was made of the effects of estrone on the rate and amount of specific antibody production in rabbits, formalinized type I pneumococci being used as the immunizing agent. One mg. estrone in sesame oil was administered by intraabdominal injections three times weekly. The injections were begun 2 weeks before administration of the vaccine and continued throughout the entire immunization period. The vaccine was given according to the "four week complete system" of Goodman,[4] each animal receiving 4 series of 4 daily injections with small but increasing doses of the vaccine with a 2-day rest period between series. Blood was usually drawn 10 days after the last vaccine dose and tested for agglutinin and mouse protective titers. In some cases blood samples were drawn at 5-day intervals through the immunization and post-immunization period.

In a typical test 12 carefully selected female rabbits were divided into two groups. One group of six rabbits was given a 2 weeks' preliminary estrone treatment. Both groups were then sub-

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

jected to the routine 4-week antipneumococcus immunization. Ten days after the final vaccine dose the control group yielded serums with an average specific agglutinin titer of 1:21. The average titer for the estrone-treated group was 1:173. This suggests a 6-fold increase in specific antibody production as a result of estrone therapy. Simultaneous tests showed that 0.5 cc. of the serum of the estrone-treated group protected mice against 40,000 M.L.D. of highly virulent type I pneumococci. The control group protested only against 3000 M.L.D., suggesting a 13-fold increase in specific protective titer as a result of sex-hormone therapy.

In other groups of rabbits the relative speed of antibody production was determined by periodic titrations during the process of immunization. In the control group circulating antibodies were not demonstrable till 20 days after the initial vaccine does. In the estrone-treated group antibodies were demonstrable as early as the 10th day. The control titer reached its maximum on the 30th day, and then fell to zero by the 50th day. In the estrone-treated group antibodies persisted well beyond the 70th day.

Similar results were obtained with castrated male and female rabbits. The general conclusion drawn from these experiments is that the administration of estrone before and during the process of immunization produces a remarkable increase in both specific agglutinin and specific protective antibody titer in both castrated and noncastrated rabbits of both sexes. Antibody production starts much earlier as a result of estrone-therapy, reaches a higher titer, and disappears more slowly than in nontreated controls.

If adequately confirmed, this immunopotentiating action of estrone may have numerous practical applications in the commercial production of antiserums and in numerous fields of clinical medicine. Moreover, the finding is of basic biological interest, since it suggests a new teleological rôle for the sex-hormones, a purposeful augmentation of the humoral defenses, furnishing additional environmental protection for the growing embryo. The physiological method by means of which estrone increases the immunopotential of the reticuloendothelial cells, however, has not yet been determined.

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The point is, not how long you live, but how nobly you live.

—Seneca, *Epistulae ad Lucilium*. Epis. ci, sec. 15.

VACUUM STERILIZER

A promising new method of sterilizing porous materials by vacuum exposure to germicidal gases is currently suggested by Salle[1] and his coworkers, of the Department of Bacteriology, University of California, Los Angeles. Experience has shown that the commoner bacterial contaminants (e. g., S. aureus, E. coli, and B. subtilis) are usually not killed by 2 hours' exposure to formaldehyde vapor under ordinary atmospheric pressure. The California bacteriologists found that the same microörganisms are killed in from 5 to 10 minutes if exposure is made under greatly reduced atmospheric pressure. To effect this sterilization artificially contaminated glass slides or dental cotton rolls were placed in a vacuum chamber which was evacuated to 29 mercury inches or 1 pound residual atmospheric pressure. Formaldehyde gas was then generated in the vacuum chamber in sufficient amounts to produce a one-inch drop in the vacuum. Of the eight bacterial species used in these tests, six were completely sterilized by the end of 5 minutes. Even their most resistent bacterium (B. subtilis) succumbed in 10 minutes. The authors believe that this increased efficiency of formalin vapor is due solely to its increased penetration into the contaminated materials. They conclude that "the method is efficient, cheap, easily performed and indispensable for the sterilization of objects likely to be injured by the application of dry or moist heat." Thus far acid-fast bacteria and pathogenic viruses have not been tested by the partial vacuum method.

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"Science and learning are definitely internationalized, and whether we wish it or not an indelible pattern of unity has been woven into the society of mankind. An American soldier wounded on a battlefield in the Far East owes his life to the Japanese scientist, Kitasato, who isolated the bacillus of tetanus. A Russian soldier saved by a blood transfusion is indebted to Landsteiner, an Austrian. A German soldier is shielded from typhoid fever with the help of a Russian, Metchnikoff. A Dutch marine in the East Indies is protected from malaria because of the experiments of an Italian, Grassi; while a British aviator in North Africa escapes death from surgical infection because a Frenchman, Pasteur, and a German, Koch, elaborated a new technique. In peace and in war we are all of us the beneficiaries of contributions to knowledge made by every Nation in the world."—The 1941 Report of the Rockefeller Foundation.

The rural dweller in the United States has, on the average, four or five years longer life than the urban resident. Among white males dwelling in rural areas the average length of life is 62.09 years, while for urban residents, it is 56.73 years. The corresponding figures for white females are 65.09 years and 61.05 years. These figures are based on the calendar year 1930.—Louis L. Dublin, Ph.D.

ORIGINAL ARTICLES

Scientific and General

THE CARE AND MANAGEMENT OF THE VOLUNTEER BLOOD DONOR*

JOHN R. UPTON, M. D.
San Francisco

BLOOD BANK staffs throughout the country have a triple responsibility; to the recipient, to the donor, and to their own Blood Bank. I shall touch briefly on a few matters pertaining to the donor; in the last analysis, his is the essential contribution in the bottle.

SOURCE MATERIAL

The following observations were made on 11,586 volunteer blood donors: 6,586 of these passed through the doors of our nonprofit Irwin Memorial Blood Bank of the San Francisco County Medical Society from June, 1941 to May 19, 1942.

A first-time blood donor is always frightened, no matter how he tries to camouflage his feelings. This is not to be wondered at. So long as he can remember, the sight of his own blood symbolizes to him, the word pain, be it a cut finger, a lacerated knee or a burned hand. He comes in fighting himself and the primitive urge to survive. Blood to the average layman is still a mystery fluid; he knows that if he has enough he lives, if he loses too much, he dies. The wonder is that so many people present themselves for this, our modern humanitarian service. Life and Death. Fear and Pain: these basic emotions are deeply ingrained in men, and they cannot be erased by a glib catchphrase or a cleverly turned slogan. An impelling force must urge the hesitant man into being a determined blood donor. An awakened patriotism for his country, a deep religious fervor, the stubborn love of a man for his ailing child—tap these eternal emotional springs and the donor lines will never slacken. In the United States, as yet, we have suffered no Pearl Harbor, no Coventry, no Rotterdam; if we had, we would not have to ask for donors.

We cannot pick out any stratum of our complex society as being the most desirous of helping. Clerks, society girls, toilers, bankers, etc., all donate their liquid quota, but that great section of society lying between the haves and the have-nots forms the reservoir from which most of our donations are drawn.

THE GROUP INSTINCT

The herd instinct is graphically portrayed while recruiting volunteer donors. Our Blood Bank speakers would rather talk to groups than to individuals; for the camaraderie between members of the group is infectious, the humorous raillery compelling, and the wish to be "one of the boys" most eloquent to our end result of securing donors. Our speakers' time is likewise valuable and their results are multiplied. Influence groups, arrange appointments so that they may come together as a body. The inherent desire of human beings to be well thought of in their own set is strong; even timid folk will volunteer if they can go with "the gang." Our experience has been that, of the number who sign up, 50 to 60 per cent never present themselves at the Blood Bank.

INITIAL APPROACH TO DONOR

I particularly stress the mental and physical capabilities of the first person to greet the prospective donor. In our Institution, the part falls to the assistant Secretary and Receptionist. Courtesy, tactfulness and charm on the part of the first staff member greeting the hesitant donor will largely determine the difference between a 200 c.c. worthless draw, and a full 500 c.c. take. Let no one belittle the Receptionist; she is one of our key figures. This fact is also true of the Telephonist; her voice spells the difference between no blood at all, or a willing donor. Too many prospective applicants have been turned away by the "Indifferent Telephonist." We tried several girls before finally securing one who could dexterously and amicably settle the many ticklish problems that arise before and after the liquid donation.

Volunteer donors will smilingly take bare walls, bare floors, and bare cots if need be, but they will *not* take the cold impersonal guinea pig method adopted by some Blood Bank staffs. Large-scale blood withdrawals, day after day, required expert teamwork on the part of the staff; donors literally are placed on a modern production line. A skilled and careful craftsman will lovingly care for the intricate but inanimate motor car as it passes under his hands, and so must each human machine be quietly, cheerfully and considerately handled. All too frequently the cryptic notation on the donor's card "small veins" is, in reality, a "cover-up" for some imperfection in the assembly line, be that defect a snub from a smug hostess, an inadvertent remark made by a tired nurse, or the curt impersonal attitude of the doctor. The Staff must show the keen interest that they should feel for these, their patients; for, mark it well, they are their patients. I would caution against pushing the Staff too hard, they can "take it" for several days, but after that something happens—that something is contamination. Dry taps or small quantity takes are expensive in equipment and personnel time; they must be reduced to a minimum.

ROUTINE PROCEDURES

Such essentials as the short medical history, pulse rate, blood pressure, temperature and an accurate hemoglobin determination are necessary Blood Bank procedures, and must be routinely

* From the Irwin Memorial Blood Bank of the San Francisco County Medical Society.
Read before the American Human Serum Association, Atlantic City, N. J., June 8, 1942.

performed and recorded on the donor's card. Standards promulgated by the National Research Council are quite adequate and, if conscientiously followed, will protect the recipient, the donor and the Blood Bank. Physical deviations of donors from these accepted standards must be accepted or rejected by the doctor in charge, and not by a lesser member of the Staff. It requires rare tact to refuse some people; a disgruntled and perhaps suspicious person can cause a great furore in the community if he is allowed to leave the Blood Bank with a supposed grudge.

FAINTING PROBLEM

A physically small person does not worry us the way he used to. Naturally, we prefer a donor whose weight is over 120 lbs., but a short, stocky person withstands the slight ordeal of blood-letting easily. Beware of tall, thin people. Most of our faintings occur in this group. After a veni-puncture, more care is shown them, such as a longer period of rest, and they are advised to take it easily the rest of the day. The reason for these somewhat alarming reactions in tall, thin people is a simple problem of bio-physics. We prefer the shorter, stockier donor and, preferably one who falls into the 36-to-50 year age group. Younger people faint more frequently than their elders. It almost seems that in sending the youth of our land to fight, Providence permits the 36 to 50 year old group to stay behind in order to provide them with blood; certainly added years gives not only mental stability, but more vasomotor stability.

PRELIMINARY INTAKE OF FLUID AND FOOD

The pertinent question of food and fluid for blood donors deserves more thought. A. C. Ivy and associates recently reported their experimental work on dogs, and found that there were fewer reactions in their animals when both donor and recipient dog had fasted. Their careful analysis shows that, fast one and not the other in the recipient-donor set up, and the percentage of reactions rises—a new and provocative idea, and one to be further clarified in human beings. Of course, some patients requiring transfusions are inadvertently fasting because of their diseased state or debilitated condition. We only ask our donors not to eat *fats* for four hours before presenting themselves. We like our donors to take a little fatless fluid and food just prior to their reporting at the Blood Bank. It is quite true that blood from a fasting donor yields clearer plasma or serum than that from one who has partaken of even fat-free fluids and food. On the opposite side of the ledger is the fact that the longer the donors fast, the more frequent are the number of faints. Immediate or delayed faints will not help the reputation af a Blood Bank. We must all strive to lessen their incidence. Our Staff members greatly dislike to start a busy day with a faint. They say this stigma seems to unconsciously touch each succeeding donor and they notice a tautness, a certain uneasiness in the donors which requires extra care to allay. I sense that the Staff also is more brittle in temper after some untoward incident, and this straining quality of theirs may be transmitted to the donor.

DELAYED REACTIONS

Our biggest bugbear is the delayed reaction; we define the term as a reaction which takes place after the donor has left the Institution. At least half an hour elapses between entry and exit of the donor with at least ten minutes of this period being given over to rest in the drone position. Our mean bleeding time for both sexes is five minutes. We have no statistics on these delayed reactions as yet, but our various City Emergency Centers are coöperating fully in reporting them when they occur. Such Centers likewise have been requested to minimize the incident to the affected donor. This last phase is highly important, for here is an opportunity for malpractice suits to be launched by ill-advised people, or by Axis sympathizers.

CAUTION CONCERNING HARD CANDY

We would caution on the giving of hard candy prior to or during a drawing. This in substance is sound, as quick sugar energy is beneficial. We were experimenting with various rapidly absorbed energy foods and fluids that were given to our donors just prior to the veni-puncture when an incident occurred. The near tragedy of this donor stopped the hard candy practice in our Blood Bank. The donor fainted, the candy became lodged in his trachea and it was only the quick action of our Staff Doctor in extricating the impediment that prevented a possible catastrophe.

COMMENT

We try to maintain our large donor room at a temperature of 68-70°F. More important than heat, from the donors' standpoint, is that of air stagnation. Air should circulate freely through the room. This is an easy matter when the cots are not confined in cubicles; but when the individual or double cubicle system is utilized, greater care should be made for adequate air movement. Cigarette smoke may benefit the few after their donation, but it upsets the majority. We allow no smoking in the donor room.

In our first few months of operation, the percentage of female donors to male donors was three to one. At the present time, the sexes are about equal in number; women like morning hours, between 9 and 11, while males prefer the hours between 4 and 7 p. m. Work hours have naturally been the main factor in causing the male influx late in the afternoon. We expected these end-of-the-day workers to show some fatigue changes; this, however, has not been the case. Perhaps the forty-hour week is responsible!

Female finger nails early attracted our attention, and an interesting fact was noted. The prevalent fashion for women to allow their finger

nails to grow to prodigious lengths makes it physically impossible for such women to clench their fingers into the palm of their hand when giving blood. Muscular action is therefore necessarily slight, and the rate of blood flow is slackened; when such a woman tries to clench her fist, sharp nails press into the flesh of her hand—so, she does not clench. A simple and very efficient expedient was found in the form of a padded hard rubber dog-bone, such as is given to puppies to play with and to bite. A hard rubber dumb-bell or a short segment of garden hose will also serve the purpose. We place one of these rubber "bones" in the hand of the female donor and say: "Chew on that!" The result is an increased flow of blood and a subsequent shortening of the bleeding time. Most donors like to have something to squeeze while donating their blood; their fingers do not tingle, and as this symptom is the only effect noted, its abolishment is worth while.

CAUTIONS

If there is the slightest possibility of an hematoma developing at the veni-puncture site, we are careful to notify the donor as to its slight significance, and the simple rules for treatment of the condition. I am sure all of us have received midnight telephone calls from occasional worried persons when they discovered the rather fearsome blood staining of the subcutaneous anti-cubital area tissue. Such anxious folk are asked to report to the Blood Bank for an examination and treatment. If this is difficult for them, one of our Staff makes a home visit. Several irate and potential trouble-makers have been mollified by this courtesy—it pays.

TECHNIQUE

The doctors or supervised nurses who perform the actual blood letting must scrupulously follow this advised technique in terminating the veni-puncture. If the bottle used employs the closed-system gravity method, the sphygmometer or tourniquet pressure must not be released until the tube leading to the bottle is clamped. This necessary precaution prevents any incident occurring from the possibility of a positive pressure being created in the drawing bottle. If the arm-band pressure is released before the bottle clamp is shut, the donor may take in considerable air via the punctured vein. This is especially true if the donor suddenly faints, for then a reversal from the normal to a greatly lowered blood pressure would initiate the process which might terminate in a massive air embolism.

If negative pressure appliances are used on the air filter inlet-outlet system of the drawing bottle, especial watchfulness is necessary. Several instances have been brought to my attention by other drawing centers where the attendant unknowingly built up a positive pressure in the bottle and thus considerable air was forced into the punctured venous system. I am almost convinced that the negative-positive pressure bulbs and other similar appliances are dangerous; certainly, if they are used, they should be tested each time they are applied to the bottle.

SABOTAGE RUMORS

I was considerably alarmed during the first few weeks of this war by vicious verbal sabotage. A new rumor a day was about the average, and most rumors were definitely of a damaging nature. Immediate and firm measures were taken to locate their source. This, however, was not always possible, and so the radio and newspapers were utilized to mitigate the effectiveness of this deliberate falsehood campaign. The unfortunate thing was that many rumors were started by misinformed folk. Damage, however, was quite as effective to our blood-procurement cause as that resulting from the subversive action of Axis sympathizers in any defense industry. Blood and its use appears to hypnotize the average lay person, and they listen with avidity to tales pertinent to blood letting. This fact has been well noted by certain subversive groups and we are continually on guard to combat false stories. A policy of public enlightenment on Blood Banks, and their rôle in the war effort, is advisable. The recent trend to publish articles on Blood Banks in our national magazines is laudatory; but after reading a few, I would suggest such print be passed on and checked by a competent Blood Bank doctor. Several articles were "sensational" and were far from being accurate.

NO DISPLAY OF BOTTLES

Most donors ask to see their own bottle of blood after it has been drawn. If they insist, we show them the bottle when only a few c.c.'s have been drawn; for otherwise, when they see the full pint of blood, the most common phrase has been: "Did all that come from me?" The rapid change of facial colour, the lowering of the blood pressure and other clinical manifestations of syncope showed the psychic shock they had sustained, so we try not to show the donors their blood any more. Likewise we shield the bottle on the opposite couch so it cannot be seen. Our nurses and nurses' aides are expert in talking about usual everyday occurrences, and a deliberate attempt is made during the drawing to keep the donors' mind off the slight operation they are undergoing. However, the tenacity with which the majority of donors will attempt to pull the conversation back to the topic of blood again, bespeaks the tremendous interest in this subject. We subtly discourage such references, as primarily we are anxious to obtain a full 500 c.c. take without the donor suffering any inconvenience. Allow unrestrained comments to be made about blood in a donors' room, and it is actually possible to graph the decreased take of blood.

IN CONCLUSION

In short conclusion.—War's urgent necessity, and the skill of our scientists, have made us

guardians of an inexhaustible supply of liquid wealth. That being so, we must turn our thoughts and some energies to the future medical welfare of our Nation. The present volunteer blood donor must not become a forgotten man when this war's turmoil is over. His potential service is too valuable to the Nation's economy. Democracy's peace-time battlefields are the highways, the industrial plants; the daily blood requirements for their maimed and injured are enormous.

Our medical research workers are striving desperately to fashion a substitute for human blood plasma and ultimately they will succeed. To us has been given a therapeutic weapon of great value; the medical profession must safeguard that weapon from abuse and from dissipation.

384 Post Street.

BRONCHOSCOPY: ITS RÔLE IN THE TREATMENT OF ASTHMA

JOHN L. GOMPERTZ, M. D.
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BRONCHOSCOPY has been one of the many modalities used and abused in the treatment of asthma for many years. In some cases its use is a spectacular success, while with other patients, it is a dismal failure. In examining the causes for both of these results, certain facts stand out which will be emphasized in this paper.

Clerf[1] has pointed out that a wheeze is simply an audible manifestation of a narrowing of the airway, and should be investigated as a symptom of obstruction. A careful history, with a complete physical examination and judicious use of the x-ray, will eliminate many cases that are not true bronchial asthma and, therefore, may be disregarded here.

Bronchial asthma should not be considered as a separate disease entity, but rather as a complex of conditions culminating in dyspnea. The underlying conditions are allergy and infection, but it is the relief of the severe dyspnea, as well as the prevention of its recurrence, plus facilitating pulmonary drainage, that concerns the bronchoscopist.

ETIOLOGY

The real cause of the severe dyspnea that occurs in asthma is obstruction of the airway somewhere along its course. This obstruction is due to one or more pathologic conditions of the bronchial tree and its various component parts. Allergy and infection play leading rôles in producing those conditions.

Miller[2] and his associates have pointed out four causes of bronchial obstruction in allergic patients:

1. Spasm of the bronchial musculature, producing bronchial constriction.

2. Thickening of the walls of the bronchi and bronchioles from edema, hyperplasia, hypertrophy and cellular infiltration.

3. Secretion of a very thick and tenacious mucous in the bronchi.

4. Paradoxic collapse of the bronchi during cough and expiration.

A fifth cause may well be the localized, stricture-like narrowing of a bronchus, often found in asthmatics and described by Prickman and Moersch[3]. Most of the people in this last group give a history of pneumonia.

PATHOLOGY

Huber and Koessler[4] have described the following changes in the bronchial tree:

1. Thickening of the walls of the smaller bronchi involving all coats.

2. Spasm of the muscular coat.

3. The mucosal glands are usually swollen and very active. In cases without sputum the glands are found to be atrophic.

4. Infiltration of the bronchial wall by lymphocytes and eosinophyles. Bronchial smears will often show a high eosinophyle count.

5. Curschmann's Spirals, which are simply an arrangement of mucous threads within the casts of the bronchi, sometimes containing Charcot-Leyden crystals.

Moore[5] quotes an excellent description, by G. R. Moffitt, of the histopathologic changes that occur in the bronchial musoca. Moffitt concludes that one or more of the following changes occur in the ciliated columnar epithelium of the bronchi in asthmatics:

1. Loss of the ciliary motion which produces the current.

2. Complete loss of all ciliary motion (he describes two types of motion).

3. Actual loss of cilia.

4. Fatty degeneration.

The net result of the above changes is that the patient has great difficulty in draining the bronchial tree by coughing.

BRONCHOSCOPIC FINDINGS

Among Clerf's[1] cases, there were two noteworthy bronchoscopic findings in true asthma.

The first was collapse of the walls of the trachea and bronchi during cough and forced expiration. This condition varies greatly in degree among different patients whom we have observed, and its cause has been a source of speculation. However, it is not bronchial spasm.

The second finding was the presence of abnormal secretions. These are sometimes so thick that they will not flow down the side of a glass tube. The best results in the treatment of asthmatics by bronchoscopy are secured in patients who have chronic tracheo-Bronchitis with considerable secretion, which may be either mucoid or purulent in character. This is what Weille[6] calls Intrinsic (Exudative) Asthma.

There are other conditions with which asthma may have a causal relationship, and in the treatment of which bronchoscopy may play an important part.

In 1930, Wilmer, Cobe and Lee[7] noted a definite relation between allergy and postoperative atelectasis. In their series of cases of postoperative atelectasis a high percentage gave a definite history of allergy.

Further confirming this observation, many cases of pulmonary atelectasis, and some cases of massive collapse of the lung in asthmatic children, have been reported by Tucker.[8] Peshkin and Fineman,[9] Kahn,[10] Maxwell[11] and others. In all of these cases, either asthma or some other definite allergic state, was considered to be the underlying cause of the condition, and in the great majority of cases relief or cure was obtained by bronchoscopy.

Bronchial asthma, with its obstructive phenomena, has been suggested as an antecedent of bronchiectasis, and this is much more likely in those asthmatics having definite bronchial stricture.

TREATMENT

Bronchoscopy is of benefit to those asthmatics who have either bronchial secretion in large amount with diseased epithelium that hinders drainage, or where the secretion is so thick that cilia, coughing or posture have no effect upon it. Direct aspiration is a boon to these patients.

Lukens[12] has pointed out that by bronchoscopy, specimens of bronchial secretion may be obtained that are free of oral contamination. Some patients are greatly benefited by autogenous vaccine made from such material, when they receive no benefit from vaccine made from smears of their nose and throat.

The patients showing collapse of the walls of the trachea and bronchi, are benefited by bronchoscopic drainage many times, even when the secretions are not abundant. This procedure seems to lessen the inflammation and hence the collapse of the walls.

The cases that are not benefited by bronchoscopy are those of mistaken diagnosis or those whose wheezing is due to some other disease condition. There is a large class of true asthmatics also who are not benefited by this treatment. They are the people who don't have much secretion, whose attacks are precipitated by known allergens, and are prevented or relieved by appropriate desensitization and medication. Bronchoscopy and the patients are both abused by its use upon them.

CONCLUSIONS

Bronchoscopy is of definite benefit to the asthmatic patient whose bronchial tree needs draining and who is unable to accomplish this unaided. Direct aspiration to remove excessive or very thick bronchial secretions will not only relieve the dyspnea, but will aid in controlling bronchial infection if present. We have seen asthmatic patients made quite comfortable, and kept so by periodic bronchoscopic aspiration.

To achieve good results, the infection or allergen, that causes the bronchial irritation and mucosal response, must be eliminated. Appropriate allergy treatment must be combined with bronchoscopy.

Those patients who have very little secretion, or whose bouts of dyspnea are promptly relieved by an injection or other treatment, are very seldom helped by bronchoscopy.

Bronchoscopy is definitely an aid in clearing up cases of postoperative atelectasis.

SUMMARY

1. The etiology and pathology of bronchial asthma are reviewed.

2. The bronchoscopic findings in bronchial asthma are noted.

3. The association between allergic states and pulmonary atelectasis and massive collapse is stressed.

4. The type of asthmatic patient benefited by bronchoscopy is described.

5. Certain types of asthmatics who were not benefited by bronchoscopy are enumerated.†

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LEG LENGTHENING OPERATION: ITS PRESENT STATUS*

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SHORT legs are common in orthopedic clinics. Injuries of epiphyses in legs still growing, diseases such as tuberculosis and osteomyelitis involving the growth plates, poliomyelitis, fractures that have healed with shortening, congenital short leg, untreated congenital dislocation of the hip, are some of the causes of short legs. Over the past 12-year period we have done at least 150 operations to equalize leg lengths, 109 of which were the leg lengthening operation. This means an average of about one patient each month.

There are five ways in which difference in leg length may be approximated. The two less important methods will be discussed first.

AMPUTATION WITH PROSTHESIS

This method is seldom used, mainly because the surgeon too often fails to see the possibilities. Under certain conditions it is ideal, in fact the only method to consider. Consider the young

† For references to article on Bronchoscopy, see page 20.

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From the Clinics of the Orthopedic Hospital, Los Angeles.

adult poliomyelitis patient with severe paralysis in one leg with marked shortening, but who fortunately has still fairly strong abductor and extensor muscles of the hip, at least adequate to control an artificial leg. Instead of a lifetime heavy brace with a high shoe raise, a weak useless leg, a limb of unpleasing cosmetic appearance, this patient should have an amputation at the knee, with an end-bearing patella stump. The legs are now the same size, the same length, better appearance and better function. This patient will be everlastingly grateful to you for your insistence on amputation.

Consider, also, the patient with a congenital short leg of 4 inches or so, with a small, deformed club foot, possibly with limited painful function due to surgery that turned out poorly. This patient is an ideal candidate for amputation in front of the os calcis, saving the heel for end-weight bearing or amputation at the conventional level at the junction of the middle and upper thirds of the leg.

EPIPHYSEAL STIMULATION

This operation has had support from individual surgeons from time to time, but on the whole the results are inconsistent and disappointing. In this operation a number of drill holes are made across the tibia or femur near the epiphyses at the knee or hip, or both, and some prefer to stuff some of the holes with heavy catgut to act as an irritant in the hope that increasd vascularity will hasten growth in length. The rationale of the operation is based on the fact that it has been repeatedly observed that fractures, especially of the femur in young children, removal of bone grafts from the tibia, and chronic osteomyelitis near the epiphyses, may cause that leg to grow from ½ inch to 1½ inches too long.

It is ideally used in the young child with a congenital short leg in which observation shows increasing discrepancy in leg lengths. Unfortunately, we never know just how much good we have accomplished, because the best we can hope is that the difference will not increase. Anything we may gain is pure profit, and will make future leg-equalization surgery less radical. Some surgeons report a gain of ¾ to 1¼ increase in length.

EPIPHYSEAL ARREST

This operation is upon much sounder foundation than epiphyseal stimulation. From our studies of growth, we know fairly accurately how much each epiphysis of the femur and tibia and fibula will contribute to the growth of a leg at any given age. Conversely, then, we know that if a certain epiphyseal line is destroyed at a given age, then the growth in length will be retarded that much.

The operation is safe and the convalescence is short, but it has certain limitations and objections. In the first place the surgery must be done while the leg is still growing and the expected growth from the epiphysis or epiphyses must be equal to the shortness in the opposite leg. Once that age is passed surgery cannot completely compensate for the difference in length when growth is over.

Secondly, our figures on expected growth from various epiphyses represent an average of a number of studied cases. When an individual patient comes to us we are forced to use a general rule for his specific case which may not always be accurate. Computation is made still more difficult if there has been a partial epiphyseal closure in either leg due to injury or disease.

Thirdly, the result of the operation is not entirely known until after the end of growth and, furthermore, we do not have enough end-result studies to actually know the whole truth; and for this reason we do not know enough about possible deformities resulting from imperfect surgical closure of the epiphyses.

Lastly, the height at maturity has been shortened.

In spite of all these possible objections, we do now know that many good results are obtained and the operation has been gaining in favor.

LEG SHORTENING

This is a very positive way of equalizing leg lengths. It is positive in that the preplanned amount of bone can be removed and there is no waiting until the end of growth to see how much has been accomplished. The operation is no simpler than leg lengthening but is somewhat safer; there are fewer complications, and the convalescence is shorter.

It has the disadvantage of making the patient shorter instead of taller, a fact which is more important if the patient is of short stature. Sometimes the patient, as well as the surgeon, are hesitant to operate on the good leg, especially if the short leg is of very poor function. They may not wish to risk the possibility of two poor legs.

Leg shortening should be done in the femur, preferably in the extreme upper end while leg lengthening should be done below the knee.

LEG LENGTHENING

To Abbott of San Francisco must go the credit for the impetus in the interest of leg lengthening in this country. As a result of his early work we started this operation and have been doing them steadily since. At present we are doing more leg shortening and epiphyseal arrests, but we have done 109 leg lengthenings in the past twelve years, and consider it still a sound safe operation in the hands of the experienced.

It has the advantage that it increases the height and restores the patient to the stature that nature intended. It places the operation on the limb of poorer function. The disadvantages of the operation are the complications that may result.

Generally speaking, a poliomyelitis leg may be lengthened from 1¾ to 2¼ inches with comparative safety and the unparalyzed leg from 1¼

to 1¾ inches. It is possible to obtain more length but if we are content with the above limitations, there will be fewer complications to report.

In the average case, the lengthening process proceeded at the rate of 1½ mm. per day, the lengthening apparatus was removed in 2½ months, the plaster cast removed in 6 months and full weight bearing begun at 9 months.

Success of the surgery depends to considerable extent on everlasting vigilance during the lengthening process. Due to the heavy calf muscles there is marked tendency to anterior bowing of the tibia. This failure to maintain good alignment of the fragments bring about most of the grief associated with the operation.

Bowing means separation of fragments, which means delayed union. Bowing also will cause the fragment ends to project through the skin, or at least to cause pressure necrosis of the skin over the shin and later sloughing of soft tissue and exposure of the bone. This accounts for the infections that sometimes develop and the secondary surgery that is necessary to clear up the bone infection.

Too much lengthening will cause limitation of motion in the ankle due to the long-continued pressure force on the ankle. In two instances, the fibula pulled up from the ankle to give a valgus foot deformity, and in a few the head of the fibula pulled down from its mooring at the knee but this did not cause any instability of the joint or decrease in function or pain.

Experience has taught us that lengthening of the femur is not a safe procedure, and we now do all our lengthening below the knee.

Most surgeons feel that leg lengthening should be done after the growth period is over, because we then know the amount of permanent shortening. There are some exceptions to this rule, however. It occurs many times that the shortening is already as great as it will be safe to lengthen the leg. Therefore, there is no point to wait longer because the younger patients grow new bone faster and better tolerate the stretching of soft tissue incident to the operation. Also, it is better to do the other reconstruction surgery in the poliomyelitis leg after the leg lengthening, if it is possible to so arrange it. Also the difference in leg lengths is sometimes of such a degree that it will be necessary to combine the leg lengthening with either a leg shortening or an epiphyseal arrest at a later date.

Congenital short legs have increasing discrepancy in length for a time, but later level off and the difference then usually remains the same. Such legs may be lengthened before the end of the growth period. Six legs were so lengthened, and there was no further discrepancy when growth was completed.

If the shortness is due to epiphyseal destruction, then obviously the short leg will not keep up with the normal leg when the operation is done before growth is over. Also, we have learned that poliomyelitis legs with much paralysis, and lengthened when young, will not keep up with the good leg after surgery.

The complications that may occur are not so serious in the partially-paralyzed leg, because these patients usually require other reconstruction surgery on the leg, and this, together with the added deformity incident to the surgery of the leg lengthening operation, may be combined at a later date. About 60 per cent of the legs that have been lengthened were due to poliomyelitis.

In this type of leg with considerable weakness at the hip or knee, the legs should not be made the same length, but should remain ½ to ¾ inches shorter even after the lengthening operation. If the weakness is chiefly in the leg and foot, the legs may then be made the same length. Taking into consideration that our first cases of leg lengthening were done without precedence to guide us, the results after a 12-year trial have been more than satisfactory.

Some 65 per cent were classified as extremely good, 22 per cent good and 13 per cent poor. Now that we know the dangers and potential dangers, the poor results will be decreased although it should be understood that the operation will never be without some hazard.

SUMMARY

1. Five ways of making a short leg longer are described. Each has its advantages and disadvantages.

2. The results of 109 cases of leg lengthening over a 12-year period are described. The operation is practical and sound when done below the knee.

3. Leg shortenings above the knee and epiphyseal arrest operations are now more common than leg lengthening. The complications are less and the convalescence shorter. The chief disadvantages of both are that the height is decreased and the surgery is done on the good rather than the poor leg.

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CLASSIFICATION OF MYELITIS*

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IN its defined meaning the termination "itis" signifies inflammation. Usage has applied this designation, however, to a variety of conditions, some doubtfully inflammatory in nature as, for example, certain types of arthritis. The same may be said of "neuritis," a much-misused term, and also of myelitis, with the classification of which we are concerned in this paper. Indeed, myelitis always has been a vague and ill-defined term in neurologic nomenclature. This has been due to our lack of knowledge, not solely of etiologic fac-

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tors, but also of histopathologic identification of the process concerned in diseased nervous tissues. This problem was discussed following a paper by Ferraro[1] on demyelination in the nervous system. To Globus inflammation meant pathology due to an intrinsic living agent: degeneration, primary dissolution of tissue. Ferraro and Putnam called attention to the extreme difficulty, and often impossibility, of distinguishing between inflammatory and degenerative process by aid of the microscope, or, indeed, of making a definite microscopic diagnosis of widely-different disease processes. For example, Putnam doubted that solely by tissue examination one might identify post-vaccinal encephalitis, brain trauma, or nitrous-oxide poisoning. This difficulty is well brought out in the controversy which has arisen concerning the nature of multiple sclerosis. At first considered to be inflammatory in nature, the present tendency is to regard the condition as either toxic or degenerative. To quote the noted neuropathologist, Spielmeyer: "I myself have considered multiple sclerosis to be of inflammatory origin for many years; but if somebody should say that the infiltration is only a symptomatic inflammation as a result of destruction and reparation, I should not be able to contradict him." In this connection, Spielmeyer was referring to the perivascular infiltrates, and particularly to the kind of cells they contained. It has been alleged, by Lhermitte[2] for example, that a perivascular exudate in a degenerative process never contains plasma cells; however, large numbers of these cells have been noted in mushroom poisoning. The presence of plasma cells and lymphocytes in perivascular accumulations containing scavenger cells in predominance, has been called symptomatic inflammation, i. e., secondary to the primary degenerative process.

In the United States Hassin especially has protested that the presence of the foregoing type of cells necessarily means primary inflammation. Ferraro includes eighteen differently-named diseases under the heading of patchy or diffuse sclerosis. The lack of a constant clinical picture, and unknown etiology, and the absence of a final neuropathologic identification obviously render certain cases of myelitis and allied disorders one of the perplexing diagnostic problems in neurology. In some texts, as Oxford Medicine, there is a tendency to discard myelitis as a heading. In the index of this system there are but two designations of myelitis: one, "compression myelitis," and the other "transverse syphilitic type," neither of which represents a true inflammatory parenchymatous process. The same may be said of traumatic myelitis. Uncontested examples of myelitis are generally expressed by a compounded or definitely-qualified nomenclature, such as poliomyelitis, or suppurative myelitis (abscess). The inflammatory-degenerative cord disorders, often designated as myelopathic states, may be conveniently classified as follows:

1. True inflammatory affections. Examples: poliomyelitis and cord abscess.

2. Demyelinating cord diseases, formerly called myelitis. Subacute combined myelinic degeneration of the cord is an example; multiple sclerosis with predominantly cord localization is another.

3. Vascular diseases with secondary ischemia and anoxemia, leading to softening. Examples: Heubner's syphilitic endarteritis causing so-called transverse myelitis; petechial hemorrhages in concussion.

4. A heterogenous group, as follows:
Landry's paralysis.
Neuronitis.
Guillain-Barré syndrome.
Post-vaccinal myelitis.
Myelitis following antirabic vaccination.
Myelitis in the course of the common eruptive fevers.
Myelitis following injection of foreign serum

LANDRY'S PARALYSIS

The original description of this rapidly-ascending, and often fatal form of paralysis, by Landry[3] (1859) is one of the classics of medical literature. Landry's report of his original case has been translated by Brown.[4] It may be briefly described as a disease of unknown etiology, featured by a rapidly-progressing symmetric ascending paralysis of predominantly flaccid motor type. However, there is some tactile and rather marked, deep sensory loss. The cerebrospinal fluid is normal, there is no rise in temperature. The general condition of the patient appears excellent, and the destiny of the case is decided before cerebral involvement. Death, from respiratory failure, may occur in a week or less. The mortality is high, in the neighborhood of 20 per cent. From this clinical picture, which is essentially that described by Landry, there have been many reported variants, so there is now a tendency to call this myelitic form a type, such as the poliomyelitic type, etc.

The pathology is that seen in noninflammatory and nonexudative myelitis; however, mesodermic infiltration has been reported. Swelling and chromolysis of the anterior horn cells, and degeneration of the white substance, is the usual picture.

NEURONITIS

Classified as myeloradiculoneuritis, this term has been applied to a progressively ascending motor paralysis, associated with sensory changes, deep sensory loss being more marked than superficial. The etiology has not been definitely determined. Kennedy[5] (1919) described the clinical picture. Pathology has been found in the nerves, nerve roots, spinal cord, and also in the motor cerebral cortex. This is degenerative in type, although lymphocytic infiltration has been found in the dorsal root ganglia. Casamajor[6] found edema, hyperemia in the arachnoid, and hemorrhages in the tissue spaces. There is slight if any muscle atrophy. Facial paralysis has been frequently noted. Tendon reflexes are absent or diminished

in intensity. There may or may not be fever. The spinal fluid frequently shows a marked dissociation between cells and protein: without appreciable rise in cell count, the total protein may reach 100 milligrams per cent, or even higher. The fluid in some cases, however, has been reported as entirely negative. Neuronitis has been found to occur after an interval of apparent recovery from an acute respiratory affection. Mortality is between 14 and 20 per cent, but when recovery occurs, it is complete.

GUILLAIN-BARRÉ SYNDROME

This syndrome is very similar to or identical with the foregoing, save for its milder course and lack of definite proof of cord involvement. It has been classified by the authors[7, 8] as radiculoneuritis, and differs from other forms of polyneuritis. It is characterized by a flaccid paralysis of the limbs, usually starting in the lower limbs. A marked cell-protein dissociation is a *sine qua non* of the disease: the protein may reach 1000 milligrams per cent, and the fluid may be xanthochromic. Paresthesias and occasional severe pain are experienced by the onset. Pain is produced by pressure over muscles and nerves. Superficial sensibility is but slightly disturbed, but deep sensation may be markedly affected. The paralysis is flaccid without noticeable muscular atrophy. Fever is generally absent or, if present, but slight. Complete recovery is the rule, although the disease may last weeks or months. The etiology has not been determined, although a virus infection is assumed. De Jong[9] feels that the syndrome should not be restricted to cases in which recovery results, as has been postulated by the authors, and reports two fatal cases in which changes were found both in the anterior horn cells of the cord and the motor nuclei of the medulla.

ACUTE DISSEMINATED MYELITIS (ENCEPHALOMYELITIS)

Under this heading, and keeping in mind the broader conception of the inflammatory process in terms of histopathology, is a group of affections, differing widely in etiology, but having a certain pathologic similarity—scattered lesions predominantly affecting the white substance—and presenting a combination of degenerative and infiltrative changes, the latter often in relationship to blood vessels. Demyelination surrounding small vessels has been called perivascular myelinoclasis. Some of the most common, as well as serious affections, under this classification are the post-vaccinal complications, which may affect either brain or cord: the encephalitic type is more frequent following small-pox vaccination; the myelitic following antirabic vaccination.

Hassin[10, 11] in a number of publications, has described a characteristic pathology of the central nervous system, "multiple degenerative softening," often producing marked cord changes in post-vaccinal, as well as other similar pathologic states, to quote: "It must be postulated that an unknown toxic factor directly attacked the nerve fibers without intermediation of the blood vessels, the process being analogous to the demyelinization produced experimentally by the action of antirabies vaccine extracts of brain, tetanus toxin, potassium cyanide, post vaccinal virus, and toxins from carious teeth, and other factors."

The pathology is a combination of demyelination and inflammatory changes. Islands of degeneration, designated as "soft patches," grossly resemble the firm patches of multiple sclerosis, but on microscopic study nerve and glial fibers are entirely lacking, thus differentiating the pathology from that of multiple sclerosis. These patches are differentiated from softening by occlusion by necrosis and the absence of fibrillary astrocytes and glial scars, although cytoplasmic astrocytes may be abundant. The "soft patches" consist of immense numbers of microgliocytes, most of which are transformed into gitter cells. The inflammatory change is characterized by a predominantly lymphocytic infiltration of the perivascular and adventitial spaces of the blood vessels (symptomatic inflammation of Spielmeyer). Multiple degenerative softening differs from disseminated encephalomyelitis in the exclusively inflammatory reaction of the latter.

POST VACCINAL MYELITIS

Nervous sequelae following small-pox vaccination rarely occur before the second year of life. The symptoms come on in the great majority of cases from the tenth to the thirteenth day after vaccination. There are acute presenting symptoms of headache, pyrexia and vomiting. Cranials, nerves and extremities are involved, the tendon reflexes usually disappear, and the picture is often similar to tetanus because of rigidity and trismus. Convulsions are not uncommon. The duration of the disease is from one to two weeks; the mortality is high, 37 to 58 per cent (according to Russell, in Oxford Medicine). The pathologic picture more nearly resembles acute multiple sclerosis than the encephalitides caused by viruses (Rivers).

MYELITIS FOLLOWING ANTIRABIC VACCINATION

Paralytic accidents usually occur between the tenth and fourteenth day following vaccination. After the initial stage of constitutional symptoms, paralysis of the legs and sphincters rapidly follows. An acute ascending or Landry's type has been described, a dorsolumbar type, and also a cranial and peripheral neuritic type. The mortality is about 30 per cent. When recovery takes place, it is usually complete.

MYELITIS IN THE COURSE OF THE COMMON ERUPTIVE FEVERS

Paralytic complications may occur during or after small-pox, varicella, scarlet fever, and measles. Here, again, there are encephalitic and myelitic types. In the myelitic cases motor paraly-

sis of the extremities, and sensory and sphincter disturbances occur. In measles symptoms usually come on after defervescence and when the patient has fully recovered. The mortality in this complication following measles is approximately 10 per cent; persisting sequelae have been noted in severe cases (Wilson). The pathology has been studied in six cases by Ferraro and Scheffer, who found perivascular proliferation of microglial elements dominantly located in the white substance. Occasionally, there were scattered hematogenous cells. Accompanying this proliferation was a concomitant perivascular demyelination. It seemed evident to these investigators that the noxious agent was carried from the blood vessels to the surrounding tissue. They suggested the term encephalophy, because the pathology was different from the typical inflammatory type.

MYELITIS FOLLOWING INJECTION OF FOREIGN SERUM

In susceptible individuals, this reaction may occur after inoculation of sera, specific or otherwise, but is most often observed after the administration of antitetanus serum, probably because of the frequency of its use. This reaction to foreign serum occurs in the process of sensitization—the patient becomes anaphylactic. Symptoms occur from seven to fourteen days after injection. Generalized symptoms are headache, nausea, vomiting, joint pains, and urticaria. There is a wide variance in the distribution of the nervous lesions. Symptoms referable to the brain, cord, spinal roots, and nerves have been described. Thus, paraplegic and Landry's types have been reported, as well as types resembling multiple sclerosis. The characteristic spinal picture is a paralysis of muscles supplied by the fifth and sixth spinal roots (Erb-Duchenne type of brachial palsy). The pathology predominantly affects blood vessels: vasodilatation, edema, and petechial hemorrhage. Exceptionally, cellular infiltration with necrotic areas in the parenchyma occurs. The spinal fluid may contain a moderate pleocytosis and be under pressure, which symptoms disappear with the urticarial lesions.

CONCLUSIONS

The close resemblance between nervous sequelae following vaccination and following infectious fevers (also serum sickness) has long been recognized. It has been previously suggested that either there is a delayed action of the causative infection, or that the symptoms represent an anaphylactic effect, or that the body is so conditioned by the initial disease as to render it susceptible to other and independent diseases. When attention was first called to the post-vaccinal myelitis, it was thought to be a latent manifestation of epidemic encephalitis.

A close relationship appears to exist between Landry's paralysis, as now reported in the literature, neuronitis, and the Guillain-Barré syndrome. I am convinced that at least neuronitis and the Guillain-Barré syndrome are closely related, and may be identical. Differences in the clinical picture and course may be due to the variations of type and virulence so often met with in virus affections. Landry's paralysis, as clearly defined by Landry himself (assuming that the cerebrospinal fluid was not altered) may be a definite disease entity, or perhaps a deficiency state. This latter is the position of Madeleine Brown. However, in a personal case recently observed, there was no response to large doses of Vitamin B and the patient succumbed. Since the publication of Doctor Brown's article, I have come across no reports of the specificity of Vitamin B therapy in Landry's paralysis.

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SELECTIVE ANESTHESIA*

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THIS paper deals primarily with combinations of anesthetics and methods, and not with single anesthetics which may be the ones selected. Other terms which are used are combined anesthesia, balanced anesthesia (as described by Lundy in 1925), and anoci-association as originated by Crile. Anoci-association is only one type of selective anesthesia, since it consists of a local anesthesia well-fortified by preliminary medication, upon which is superimposed nitrous-oxide and oxygen anesthesia, the essential purpose of which is to destroy consciousness. Whatever the name employed, the idea is to use two or more anes-

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thetics in minimal amounts, instead of a large dose of one anesthetic which may be dangerous to the patient.

ADVANTAGES OF SELECTIVE ANESTHESIA

Some of the factors which make selective anesthesia safer than large doses of single anesthetics are:

1. Stimuli to the central nervous system are decreased or eliminated, thus diminishing the amount of general anesthesia necessary.
2. The exhaustion caused by nervous tension of some patients under local anesthesia alone is eliminated.
3. Patients having received small doses of anesthetics respond quicker, and normal reflexes return sooner.
4. Large doses of anesthetics, especially spinal for the poor-risk patient, are extremely dangerous.
5. Shock from deep cyclopropane and ether anesthesia is eliminated.

As new agents and methods are introduced, and we become acquainted with them, we gradually work them in with other agents and methods. At the present time a good anesthetist should have enough agents and methods available to carry out almost any procedure with a minimum of risk to the patient's safety. If one method is considered unsafe, it should be discarded for a safer method or combination of methods and agents.

Indications and contraindications for various combinations of anesthetics will not be discussed. Only those combinations with which I am familiar and have found useful on many occasions. will be touched upon. Undoubtedly there are other useful anesthetic combinations.

AUTHOR'S OBSERVATIONS

Selective anesthesia for the bad-risk patient is usually based on local anesthesia: either some type of block or infiltration carried out by the anesthetist, or local infiltration administered by the surgeon. If the surgeon carries out the local anesthetic procedure, it is sometimes necessary to explain to him that, even though the patient is under the influence of a general anesthetic, the local still carries out a definite purpose and should not be abandoned after the first skin infiltration.

Skull and Brain.—Operations on the skull and brain can be carried out under many combinations of anesthetics. In patients with mental stupor or partial unconsciousness, local anesthesia or field block is desirable. Occasionally this type of patient may be uncoöperative, but can be very easily controlled with safety with small doses of 2½ per cent pentothal injected into the vein, or injected with intravenous solutions, or with one of the many special sets of apparatus used for intravenous anesthesia. The effect of the pentothal should be worn off by the time the operation is over. Avertin is not as suitable for this type of patient because of its uncertain action, long duration, and because of the occasional fall of blood pressure which accompanies its administration. After the patient has been controlled at the start of the operation, the pentothal may be sometimes discontinued and the operation carried out under local anesthesia alone. More pentothal may be added, later, if necessary. Some patients object to the administration of the local and here again pentothal may be administered to prevent the pain of the injection and then discontinued after the local is complete.

Avertin, combined with local, serves well for brain operations in patients in good condition. If the avertin and local do not give enough anesthesia, they may be supplemented with intravenous anesthesia. Small amounts of pentothal may be safely added to control the patient. If a free airway is deemed essential for a particular case, it may be necessary to administer nitrous-oxide and oxygen, and possibly a small amount of ether to facilitate easy introduction of the endotracheal tube. An obstructed airway increases intracranial pressure, and a free airway is necessary to permit easy artificial respiration.

Eye.—In operations on the eye when pentothal is to be used, it is helpful to use topical anesthesia also. This seems to prevent some of the sneezing and coughing sometimes encountered.

Teeth.—When pentothal is to be used for extraction of teeth in a noninfected area, a quick injection of novocain-adrenalin solution will cut down on the bleeding, allay some of the immediate postoperative pain, and decrease the total amount of pentothal required.

Thyroidectomy.—For poor-risk patients undergoing thyroidectomy, I feel that local anesthesia again is the basic anesthesia, with the order of anesthesia reversed; that is, the local is given after the patient is unconscious. For the very toxic patient, I prefer either a small basic dose of avertin or intravenous anesthesia administered preliminary to the local. Local anesthesia alone often upsets the toxic thyroid patient. If pentothal is to be used, oxygen should also be given. If it is necessary to awaken the patient during surgery, one may start the anesthesia with pentothal and after a small dose has been administered, nitrous-oxide and oxygen are given and the patient can be awakened at the desired time. Heavy premedication plus local anesthesia is a good form of combined anesthesia which may be satisfactorily used in the nontoxic thyroid in the placid type of individual.

Thoracic Surgery.—For extra pleural thoracic surgery, heavy premedication plus local plus nitrous-oxide and oxygen give a combination which allows the use of the electro-surgical unit. By heavy premedication is meant the use of basal avertin or the usual premedication plus intravenous morphine prior to the administration of the inhalation anesthetic. Both of these combinations are explosion-proof and fire-proof. In some cases the local may be left out and sufficient anesthesia can be obtained without using a more potent agent than nitrous-oxide. For intrapleural work where cautery is to be used, the same com-

bination may be used plus endotracheal intubation.

Abdominal Surgery.—Abdominal surgery offers the greatest opportunity for various combinations of anesthetics. Local infiltration and abdominal block form the basis for selective anesthesia in the poor-risk patient. Abdominal block is preferred because it gives more relaxation of the abdominal muscles. In abdominal block it is important that the solution be injected into the lateral border of the rectus sheath, since it is at this point that the nerves may be most easily reached with some accuracy. Tovell's technique, of making four or five separate injections into the lateral border of each rectus sheath, is one which the surgeon can very easily become acquainted with and use in many cases. This can be done while the anesthetist is administering the general anesthetic. With a good abdominal block, procedures in the abdomen can be carried out in the poor-risk patient with very light general anesthesia with nitrous-oxide, ethylene, cyclopropane or pentothal. If pentothal is to be used, it is wise to give oxygen simultaneously. The addition of nitrous-oxide, not to exceed 50 or 75 per cent, will reduce the amount of pentothal necessary, and still allow good oxygenation to be carried out. Cyclopropane is better if more relaxation is desired. The adrenalin in the local anesthetic should be omitted if cyclopropane is to be used. Spinal anesthesia is not desirable in the poor-risk patient for upper abdominal surgery. Bilateral intercostal nerve block, of the fifth through the eleventh thoracic nerves, is another type of block which gives good relaxation of the abdominal muscles, and may be used instead of abdominal block. However, if it is not done frequently, it is more time-consuming, and means a greater number of needle punctures for the patient to endure.

In the better-risk patient, small doses of spinal anesthesia plus cyclopropane is a very good combination for abdominal surgery. By small doses of spinal anesthetic, I mean not over 135 to 150 mg. of procaine hydrochloride or corresponding amounts of other drugs. The administration of cyclopropane and oxygen permits good oxygenation of the patient and tends to keep the blood pressure elevated, or does not allow the ordinary fall in the usual case. Pentothal may be used in combination with spinal anesthesia to control nausea or produce unconsciousness. However, if the spinal wears off while the abdomen is still open, pentothal may not give enough relaxation for an easy closure. If the blood pressure is low, it is best not to administer pentothal, since it may cause a further fall of blood pressure, and depression of respiration, which may be difficult to overcome. One must be prepared to administer oxygen at any time.

Kidneys.—For operations on the kidney, one of the safest combinations for the poor-risk patient is a paravertebral block of the eleventh and twelfth thoracic, and first and second lumbar nerves, plus infiltration of the line of incision plus pentothal and oxygen, or the block plus cyclopropane and oxygen. Small doses of spinal anesthetic, plus nitrous-oxide or light cyclopropane or pentothal anesthesia, are also very good combinations for kidney operations in the better-risk patient.

CONCLUSIONS

For the poor-risk patient in which the operative procedure cannot be carried out under local anesthesia alone, local or regional anesthesia, and light inhalation or intravenous anesthesia, form the safest combination in a great number of cases. Small doses of spinal anesthetic plus cyclopropane are also a popular method of selective anesthesia.

3023 Serena Road.

CLINICAL NOTES AND CASE REPORTS

EPIDEMIC KERATOCONJUNCTIVITIS: "SHIPYARD EYE"

Clifford Kuh, M. D.
Berkeley

SINCE September, 1941, when the epidemic of the keratoconjunctivitis appeared in San Francisco Bay area, there have been occasional outbreaks. Reported cases at this time are relatively mild, and acute symptoms may last a few days instead of several weeks, as was the experience in 1941. Although popularly known as "shipyard eye," cases are by no means confined to shipyard workers.

The onset of the condition is usually sudden. Outstanding symptoms are a sensation of irritation and scratching in the eye, marked lacrimation, slight photophobia, some blurring of vision, and moderate dull pain in the eyeball. Pain and soreness in the preauricular area on the affected side are common symptoms. Many patients also complain of the eyelids sticking together in the morning on awakening.

Physical examination shows the presence of varying degrees of inflammation and hyperemia of the bulbar and palpebral conjunctiva. In severe cases the bulbar conjunctiva is characterized by extreme, glassy edema, and occasionally subconjunctival hemorrhages are present. A thin membrane is sometimes found attached loosely to the palpebral conjunctiva, or lying in the lower cul-de-sac. Neighboring lymph glands and the preauricular gland on the affected side are swollen, and tender in most cases. In some patients who, at first, had only one eye affected, the condition later extends to the other eye.

Some of the individuals who have contracted this condition have developed multiple minute

* A statement by the Bureau of Industrial Health of the California Department of Public Health, Berkeley, California, December, 1942.

opacities of the cornea. In some cases, these are not sufficiently opaque to reduce visual acuity appreciably. However, in other cases there has been a distinct impairment of vision, but the ultimate prognosis for vision is good.

The following precautionary measures have been recommended to plant and shipyard physicians, nurses, and executives to prevent the spread of eye disorders in their establishments:

1. Separate examination and treatment rooms for all eye cases.
2. Provision of medical, nursing or first-aid personnel to work in the eye unit only, and not in the general dispensary or elsewhere in the plant.
3. Thorough washing of hands on part of physicians and nurses within or without the plant before treating next patient, and, if instillations into eye are used, separate eye droppers for each patient with sterilization of droppers after use.
4. Assignment to each worker of personal protective equipment for his exclusive use, such as goggles, respirators and masks, and thorough sterilization of such equipment before transfer to another worker. The placement on a special machine of a pair of goggles for general use of all workers, as is sometimes done, should definitely be discontinued.
5. Instruction of employees in personal hygienic measures, particularly the avoidance of rubbing of eyes with hands; for, in this way, tools, door knobs, etc., may become contaminated. Precautions to be taken at home to prevent the spread of the disease to members of the family, such as use of separate towels and frequent washing of hands, should be emphasized.
6. Removal of the patient from work until he has completely recovered from his conjunctivitis. It is believed this latter measure will reduce total man hours lost by entire plant personnel.

Therapy apparently does not influence course of the disease, but may give symptomatic relief. It is generally agreed that the use of strong antiseptics is contraindicated. Iced compresses, applied for 15 minutes every 2 hours, give more comfort than hot compresses. Constant covering of the affected eye from onset of disease is beneficial. Sulfathiazole or sulfadiazine ophthalmic ointment (5 per cent) is used to prevent secondary infection. Roentgen therapy, irrigation with boric acid or saline solutions, instillations of 2 per cent neoprontosil and other measures have been tried. In the presence of widespread epidemic, it has been suggested that the placing of a guard at the entrance gate of a plant, who would bar all workers with "red eyes," might be considered.

Recent research* incriminates a virus as the causative agent,[1] probably imported by travel from Hawaii. Incubation period is probably 5 to 12 days. It is believed that close contact and direct transfer are necessary.[2] Unknown factors of susceptibility presumably play an important rôle.

2002 Acton Street.

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TRAUMATIC PERFORATION OF THE BLADDER THROUGH THE RECTUM

Frank R. Guido, M. D.
Visalia

TRAUMATIC injury to the bladder, with rupture or perforation, although relatively uncommon, carries with it a high mortality rate. M. F. Campbell,[1] in 1929, reviewed the records of Bellevue Hospital and found 55 cases of rupture of the bladder in 14½ years, with a total mortality rate of 63.6 per cent.

Perforation of the rectum, or lower sigmoid, by external trauma is seldom encountered, the bulk of such accidents being caused by compressed air held close to the anus. Block and Weissman,[2] in 1926, collected 27 such cases with the high mortality rate of 70 per cent. Since then numerous such reports have appeared in the literature. The seriousness of such accidents is enhanced by the fact that they are usually the result of a practical joke.

The following case report depicts an unusually rare type of injury in which a direct perforation of the rectum and bladder occurred as a result of external trauma through the anus. In a careful search of the English literature, I was able to find the reports of only two similar cases; one of the patients recovered, and the other died. Thompson, quoted by Bailey,[3] relates the case of a schoolboy who fell on an upturned broken chair, the leg of which entered the anus, perforating the anterior rectal wall and passing up through the posterior vesical wall below the recto-vesical fold of peritoneum. Death was due to a virulent infection of the cellular tissues surrounding the bladder and rectum. Ravenel's case[4] was that of a negro who fell on a pick-ax. The sharp end entered the perineum, perforating both the anterior and posterior rectal walls and entering the base of the bladder. Recovery followed the repair of the injured bladder.

Treatment.—Recto-vesical fistula, fecal cystitis and the resulting dire consequences will follow if immediate, efficient treatment is not provided for this type of injury. Adequate treatment consists of transvesical suture of the bladder perforation and suprapubic drainage of the bladder. A tube passing up to the rectal perforation through the anus may be provided, but is not essential, as was demonstrated in the following case report.

REPORT OF CASE

Case 1.—M. S., male, age 17, whose previous history was irrelevant, was first seen about 5 P.M. on January

19, 1941. While tobogganing in the mountains he slid into the underbrush, and a manzanita stick measuring 18 inches long and three-quarter inches in diameter, perforated through the anus. The stick was immediately pulled out. After a two-hour journey the boy was brought into town. He was only in moderate shock, but complained of severe pain in the suprapubic and anal regions. Pulse was 108 beats per minute, and of good quality. Blood pressure was 106/72. Numerous attempts to void were unsuccessful, and a catheterized specimen of urine revealed occult blood. There was no external perineal injury and only a superficial abrasion of the anal margin. The anal sphincter was very spastic; but upon inserting the finger, a perforation 2 cm. in diameter could be felt on the anterior rectal wall about 3 inches from the anal margin.

Treatment.—Preparation was made for immediate laparotomy and under spinal anesthesia the rectum was thoroughly explored. Urine passed out freely through the anterial rectal perforation. No attempt was made to suture the lacerated rectal wall, and no drainage of the rectal area was instituted. A suprapubic midline incision was made and the peritoneal cavity was found unharmed. The rectovesical fold of the peritoneum was not perforated. After closure of the peritoneum, the bladder was opened extraperitoneally. On the posterior bladder wall a perforation of 2 cm. in diameter was found. This was closed with interrupted catgut sutures. The ureteral orifices were unharmed. The bladder was drained suprapubically with a de Pezzer catheter, and a Penrose drain was placed in the suprapubic space of Retzius. The patient was returned to bed in excellent condition.

Postoperative reaction was practically nil, and on the 6th postoperative day one ounce of 2 per cent aqueous solution of mercurochrome was instilled into the bladder through the suprapubic drain. None of the mercurochrome was seen to pass into the rectum. The suprapubic catheter was removed on the 12th postoperative day, and the patient was sent home on the 19th day. At no time did the temperature rise above 100 degrees F. The rectal laceration was completely healed on the 26th day and urinary function was restored to normal on the 24th day.

COMMENT

The possibility of bladder perforation must be constantly kept in mind when dealing with penetrating wounds of the lower abdomen or in the region of the anus. The presence of occult blood in the urine, although not pathognomonic, is of the highest diagnostic significance. Failure to recognize such a bladder perforation at once will result in delaying adequate treatment, with its subsequent mortality rate of close to 70 per cent. The essence of treatment consists of transvesicle suture of the bladder perforation. Suture of the rectal wall and drainage of the area of rectal perforation are not necessary.

310 West Willow Street.

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MEDICAL EPONYM

Queckenstedt Maneuver

The contribution, "Zur Diagnose der Rückenmarkskompression [Diagnosis of Spinal-Cord Compression]," from which the following extract is taken, appeared in the *Deutsche Zeitschrift für Nervenheilkunde* (55:325-333, 1916). The author, Hans Queckenstedt (d. 1918), was then *Privatdozent* and *Oberarzt* in the University Medical Clinic at Rostock.

"Wherever the dural tube is thus damaged, an exchange of spinal fluid between the two spaces thereby engendered is impossible. But even in lesser degrees of the condition described, the narrowing of the passageway must offer increased resistance to any movement of the fluid. Consequently, if there occurs any increase in pressure above the point of compress, the fluid either will fail absolutely to be displaced caudally or will do so with diminished rapidity, according to the degree of block. Such an increase in pressure may be effected in a simple manner, by vigorously grasping and compressing the throat either on both sides or unilaterally. The space available for the fluid is diminished from within by the excess of blood in the brain, and possibly from without as well, by the equalizing efflux of blood through the upper vertebral venous plexuses, thereby occasioning an increase in pressure, which is normally transmitted downward very quickly and reveals itself in a vertical tube attached to the lumbar-puncture needle. The beginning of the rise of the fluid in the tube follows almost immediately the compression of the neck, in less than one second, and the fluid rises very quickly with a kind of spurt until it reaches a momentary maximum. One soon acquires an idea of the normal interval after performing the test a few times. In the presence of compression, the rise is slow, and above all, the onset is delayed; frequently, it is necessary to produce marked congestion to obtain it at all, and in turn, on removal of the pressure about the neck, the pressure falls abnormally slowly or not at all."—R. W. B., in *New England Journal of Medicine.*

Life, if thou knowest how to use it, is long enough.
—Seneca, *De Brevitate Vitae.* Sec. II.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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OFFICIAL NOTICES

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Abstracts of Minutes: California Medical Association Executive Committee*

Minutes of the One Hundred Seventy-ninth (179th) Meeting of the Executive Committee of the California Medical Association

A meeting of the C.M.A. Executive Committee was held in the Association Offices, 450 Sutter Building, San Francisco, on Sunday, December 6, 1942, at 10:00 a. m.

1. Call to Order:

The meeting was called to order by Chairman Rogers with the following members present: Past-President Henry S. Rogers, President William R. Molony, Sr., President-Elect Karl L. Schaupp, Council Chairman Philip K. Gilman, Auditing Committee Chairman John W. Cline, and Association Secretary George H. Kress.

Absent: Speaker Lowell S. Goin, who was out of the State.

Present by Invitation: Harold Fletcher, Chairman, California Committee on Procurement; John Hunton, Executive Secretary; and Hartley F. Peart, Legal Counsel.

2. Minutes:

Minutes of the previous meeting of September 8th were approved by the Council on September 13, 1942.

3. Dr. Harry E. Henderson Elected to Fill 3rd Councilor District Vacancy:

Association Secretary stated that a mail vote of the Council resulted in the election of Doctor Harry E. Henderson, of Santa Barbara, to succeed Doctor Louis A. Packard, resigned as Councilor of the 3rd Councilor District.

4. Membership:

Concerning the recommendation by the Alameda County Medical Association of Retired Membership for Doctor Hubert N. Rowell, it was voted to recommend to the Council that such retired membership should be granted to Doctor Rowell, as of December 1, 1941.

5. Basic Science Initiative:

A brief report was made by Executive Secretary Hunton concerning the Basic Science campaign and results.

A letter was also presented from Mr. John B. Knight, of the California Associated, outlining a form of securing a sample survey from voters in several cities on reasons why they voted for or against the Basic Science Initiative.

The Executive Committee agreed to make no recommendation thereon.

6. Industrial Accident Fee Table: Wage Conference:

Reports were made by Executive Secretary Hunton concerning conferences relating to the Industrial Accident Fee Table and the recent conference concerning wages of employees of doctors and dentists.

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

7. **Nominees for Advisory Council of Board of Nurse Examiners of California:**

The Board of Nurse Examiners of California having made request for four names of members of the California Medical Association, two of whom would be appointed to their Advisory Council, it was agreed that such names should be sent. (Note: William R. Molony and Karl F. Schaupp were appointed.)

8. **Hospital Service of California: Its Proposal to Sell Surgical Indemnity Contracts:**

A letter of November 27th, addressed to Council Chairman Philip K. Gilman and signed by the Hospital Service of California, with enclosures of a letter of October 28, 1942, addressed to C.P.S. Executive Committee Chairman T. Henshaw Kelly, and a letter of November 16, 1942, addressed to the Board of Directors of Hospital Service of California and signed by Trustees of California Physicians' Service, were then taken up for consideration.

A detailed history of the issues involved was given by Doctor T. Henshaw Kelly. Discussion was participated in by Doctor A. E. Larsen, Secretary of C.P.S., and Mr. Peart and others.

Doctor Karl L. Schaupp, a member of the C.M.A. Executive Committee and also a member of the Board of Directors of Hospital Service of California, outlined his understanding of the events that had taken place. Doctors Molony, Cline, and Rogers took part in the further discussion.

Doctor Schaupp brought out the point that the four medical members of the newly-elected Board of Directors of Hospital Service of California had expressed a desire that the unfortunate circumstances which had arisen between California Physicians' Service and Hospital Service of California should, if possible, be ironed out in amicable fashion, and expressed regret that the letter of November 16, 1942, was of a nature to almost prevent further negotiations.

After further consideration, the Executive Committee voted that it would be desirable to recess the meeting, to meet again in the C.M.A. Offices, on Sunday, December 13th, and that an invitation be extended to the four medical members of the Board of Directors of Hospital Service of California (H. Gordon MacLean, M. D., Theodore C. Lawson, M. D., S. A. Jelte, M. D., and Karl L. Schaupp, M. D.) to meet with the members of the C.M.A. Executive Committee to discuss informally the subjects and activities in which the two groups have mutual interests.

Mention was also made of a confidential bulletin that had been sent out by the Medical Administrative Service of New York on hospital service conditions in California. Some interesting information was submitted in regard thereto.

9. **Procurement and Assignment Service Report:**

Doctor Harold A. Fletcher, Chairman of the California Committee on Procurement and Assignment, who was present by invitation, submitted a report concerning the present status of the work of Procurement and Assignment. He pointed out that the Permanente Foundation Medical program of the Kaiser Shipbuilding Company in Richmond is doing a very excellent job in providing industrial accident and health care for the employees of the Kaiser Shipbuilding Company, and that the Permanente Foundation owned and maintained a hospital with complete hospital and ambulance services. The staffing of this hospital and medical service has antedated the work of Procurement and Assignment, in that there were a large number of physicians on the staff who should be eligible for the military forces. With Procurement and Assignment Service gradually working out the re-placement of these physicians with Doctor Sidney Garfield, the Medical Director of the Permanente Foundation, he further pointed out that there would be a probable duplication of medical services, if, as, and when the California Physicians' Service took over the Federal Housing Projects in the Richmond area. He felt that it was very necessary that California Physicians' Service work in coöperation with the Permanente Foundation, and that with proper coöperation on both sides, a reduplication of services should be avoided during the present emergency. He also expressed the opinion that California Physicians' Service should look forward to greater expansion, particularly in the care of employees and employees' families in industrial expansion areas, other than those covered by Federal Housing Projects, and that C.P.S. might even have to consider taking over industrial coverage, as well, in certain areas.

The Executive Committee received the report by Doctor Fletcher, but made no recommendations thereon.

10. **Recent State Election:**

Informal discussion took place concerning the State election, held on November 3, 1942, in connection with Basic Science and other matters in which the medical profession was interested.

11. **Annual Session:**

The Association Secretary, as Chairman of the Committee on Scientific Work and as Editor of California and Western Medicine, for which articles would be needed, called attention to the newspaper reports of the preceding day (December 5th) in which it was definitely stated that the U. S. Navy would take over the Hotel Del Monte as a Pre-Flight School before December 31, 1942.

Discussion then took place on whether an annual session with both scientific and business meetings should be held and, if so, when and where?

On motion by Cline, seconded by Schaupp, it was voted as follows:

Resolved, By the Executive Committee that it be recommended to the Council, that the 1943 Annual Session shall be a streamlined, two-day session, commencing on Sunday morning, May 2, 1943, through Monday, May 3, 1943; and that the session be held in the City of Los Angeles, with headquarters at Hotel Biltmore.

It was also agreed that this recommendation should be called to the attention of the members of the C.M.A. Council, through an informative letter with reply blanks, so that a mail vote could be taken thereon.

(Note: By mail vote, the Council approved the plan as outlined in the resolution.)

12. **Recess Until December 13, 1942:**

President Molony stated that it would be necessary for him to be present at a meeting of the War Committee of the A.M.A. which would be in session over next week-end in Washington, D. C. President-Elect Schaupp stated it might be necessary for him to be away in the succeeding week. Motion was, therefore, made and carried that the Executive Committee recess until 10:00 a. m. on Sunday, December 13th, at which time unfinished items on the docket and new business could be considered, and on which day the informal conference could be held between members of the Executive Committee and the four medical members of the Hospital Service of California.

* * *

Recessed Meeting of December 13, 1942

On Sunday, December 13th, the recessed meeting of the Executive Committee was held in the offices of the California Medical Association, 450 Sutter Building, San Francisco.

13. **Roll Call:**

Present: Henry S. Rogers, Chairman; Karl L. Schaupp, John W. Cline, and George H. Kress.

Absent: William R. Molony, Sr. (in Washington, D. C.); Philip K. Gilman (ill); and Lowell S. Goin (excused).

Present by Invitation: H. Gordon MacLean, M. D., Theodore C. Lawson, M. D., and S. A. Jelte, M. D., all of Oakland, and members of the Board of Directors of Hospital Service of California; also present, Executive Secretary John Hunton; Dr. Harold Fletcher, Chairman of Procurement and Assignment Service of California; and Legal Counsel Hartley F. Peart.

14. **Alcohol for Hospitals:**

A letter of December 10th, received from the Association of California Hospitals, called attention to the fact that hospitals were not included in the preferential group under amended order of the W.P.B.—M-30, with respect to the use of ethyl alcohols and related compounds, it appearing that "small hospitals which do not have tax free alcohol permits because of limited diagnostic facilities, scientific work and laboratory procedures, and these would fall within the restrictions and are threatened with being deprived of the necessary quantities of alcohol."

It was voted that a letter should be forwarded by the Association Secretary in line with the suggestion made by the Association of California Hospitals.

15. **A Revised Fee Table for the Industrial Accident Commission:**

Report was made that present indications pointed to adoption of a new and extensive fee table to cover medical, surgical, and related services coming under the jurisdiction of the Industrial Compensation Law of California. It was stated that representatives of the Commission had shown a kindly interest in the plan and it was hoped that the new fee table would shortly become operative.

16. **California Physicians' Service and Hospital Service of California:**

The meeting was then thrown open for informal exchange of opinion between members of the C.M.A. Executive Committee and medical members of the Board of Directors of Hospital Service of California. Doctor MacLean, President of the Board of Directors of Hospital Service of California, outlined a brief history of the negotiations that had taken place in the past, stating that the medical members of the new Board of Directors of H.S.C. were most anxious to bring about a happier arrangement than has existed in the past. Unfortunately, the letter of November 16, 1942, which had been sent to Hospital Service by California Physicians' Service, indicated that it would not be possible to carry out some of the changes which the Board of Directors of Hospital Service of California had in mind.

The disadvantages of duplication in management, particularly in reference to procedures for acquisition of beneficiary members were commented upon. It was stated that Hospital Service of California had no desire to sell medical contracts and that only one of such, and that to a very small group, had been sold at the time when the recent break in Alameda relations took place.

Frank exchange of opinion was made concerning the unfortunate situations which had arisen through personalities. It was felt that such incidents could be avoided in the future.

Doctor Harold Fletcher, Chairman of the Procurement and Assignment Service of California, was called on to discuss the matter from the broader aspects of medical needs of the military forces and for the essential, or war industries. Doctor Fletcher emphasized the great importance of clearing up the situation, because, otherwise, the Government would be more than apt to promptly step in and set up an organization of its own that might endanger medical practice as it is now being carried on.

President-Elect Karl L. Schaupp, who is a member of the Executive Committee of the C.M.A., and also a member of the Board of Directors of Hospital Service of California, explained his understanding of the situations that had arisen.

Motion. Upon motion by Schaupp, seconded by Cline, it was voted that the Executive Committee recommend that the Council of the California Medical Association request California Physicians' Service to again make contacts with Hospital Service of California to the end that the best interests of medical and hospital service in California be promoted and unified.

During the discussion, Doctor Cline telephoned the offices of Doctor Alson Kilgore and Doctor T. Henshaw Kelly, of the Board of Trustees of California Physicians' Service, to learn whether they could come over to the meeting. Doctor Kilgore was not in the city, but Doctor Kelly stated he would join the group at luncheon.

At the luncheon, a further discussion of ways and means to bring about an improvement in relations between C.P.S. and H.S.C. took place, the conversations being very frank and cordial by all who took part.

Doctor Kelly was informed of the prior action of the C.M.A. Executive Committee and stated that he, himself, would promptly write to members of the Board of Trustees, urging California Physicians' Service to again resume relations with Hospital Service of California.

It was agreed that the consideration of details and of items that had been discussed should be left for later conference between the two organizations, and that it would be desirable to bring the same into operation, if possible, through a gradual process of evolution, rather than through radical readjustment.

17. **Adjournment:**

There being no other business, the meeting was adjourned.

HENRY S. ROGERS, *Chairman.*
GEORGE H. KRESS, *Secretary.*

WARTIME INDUSTRIAL SERVICES

With Special Comment on the Permanente Foundation, California Physicians' Service and Procurement and Assignment Service

Some Factual Information

FOREWORD

So many verbal fireworks were touched off at the recent Pepper subcommittee hearings in Washington that a review of the Kaiser medical situation in California is advisable at this time. Particularly is it important to analyze the Kaiser medical care plan and to consider it alongside the existing medical care facilities in the area where it works. The part of Procurement and Assignment Service in this picture is also worthy of mention.

Without going into the history of America's entry into the present war it is well to bear in mind that the Kaiser Company was building ships for Great Britain in its Richmond yards before this country had fired a shot. The company was also planning its expansion into United States Maritime Commission ship building in additional yards in Richmond.

Under California's industrial accident compensation

laws the company was required to give medical care to injured employees. This was done under a plan by which several commercial insurance carriers handled the industrial accident liabilities. Full time physicians were employed for the joint insurance carriers to staff the field hospital and the five first aid stations. The field hospital and first aid stations were built by the Maritime Commission in the old and new Richmond shipyards. The equipment, ambulances and supplies were furnished by the Kaiser Company.

This process had been going on for several months before Procurement and Assignment Service was established.

To bring the picture up to date, there are now about 87,000 employees at the Richmond yards. The medical care of these employees for industrial accidents alone requires a staff of physicians, nurses and first aid workers.

With the tremendous expansion of employment rolls in the shipyards doing Maritime Commission work there came to the Maritime Commission a new sense of responsibility for keeping the men on the job, keeping the ships sliding down the ways. Officials of the Commission in Washington went to work on various plans for the extension of medical care to cover nonindustrial as well as industrial illnesses of these employees. The theory behind this movement was that readily available medical care for everyday illnesses and injuries would result in keeping men on the job, or getting men back on the job in faster time, and would thereby save manhours for essential war production.

The Commission reportedly approved the Kaiser plan of setting up a medical care program for Kaiser employees. This plan, working on the proceeds of a 50-cent weekly payroll deduction, was designed to give complete medical care and hospitalization to Kaiser employees who were injured or taken ill from nonindustrial causes.

That plan is now in operation, covering some 52,000 employees at the Richmond yards who have agreed to the 50-cent weekly payroll deduction. These employees have available to them the facilities of the Maritime Commission field hospittal and six first aid stations. They also have available a staff of close to fifty physicians, a 78-bed hospital in Oakland and full nursing and accessory services.

The plan is operated by Sidney R. Garfield, M. D., who has contracted to furnish medical care to Kaiser employees. The digest of the plan furnished to employees states that the "shipyards have agreed to make weekly deductions for the employees who have subscribed and on behalf of such employees to pay the amount deducted [50 cents weekly] to Dr. Garfield."

The combined plan of industrial accident cases and nonindustrial medical cases has the following resources: The Maritime Commission provides a field hospital and six first aid stations. Mr. and Mrs. Henry Kaiser have provided over $500,000 for the Permanente Foundation and with this money have bought, rebuilt and renovated the old Fabiola Hospital of 78 beds and equipped it with complete modern facilities; a new additional wing of 75 more beds is now being added.

They have equipped the Maritime Commission-owned field hospital, now being expanded, to treat a large number of industrial as well as nonindustrial conditions near the plants and to provide temporary bed care for serious emergency cases. Complete medical, nursing, ambulance and therapeutic services are combined in this Field Hospital. The income to meet current expenses and to amortize the loan from Mr. and Mrs. Kaiser comes from the industrial medical fees paid by the insurance companies plus the 50-cent weekly subscription fees from employees subscribing to the Health Plan.

Statements made by Dr. Garfield and others associated with Mr. Kaiser indicate that the Permanente Foundation is a nonprofit venture. It is anticipated, these people say, that eventually the foundation medical plan will make a profit out of current operations; at that time it is planned that all profits shall accrue to the repayment of the $500,000 advanced by Mr. and Mrs. Kaiser. When that sum has been repaid in full, any further profits will be used for the promotion of medical research, for the rehabilitation of disabled physicians, for the endowment of hospital beds, for the teaching of industrial medicine and for other professional advancement.

Dr. Garfield, according to these statements, is employed under an agreement which allows him to draw up to $25,000 annually in salary. To date, he states, he has drawn no salary from the funds of the Foundation but has actually put into current operating funds some $10,500 of his own money. When and if the profit period of the Foundation is realized, it is anticipated that Dr. Garfield will draw his $25,000 annual salary, will be repaid his $10,500 advance and will have no further share in any profits accruing from the plan.

An inspection of the Permanente Foundation facilities by qualified physicians has disclosed that an up-to-date medical service of unquestioned merit is being performed. Hospital and treatment facilities are excellent and a well qualified and well paid staff of physicians is available for any kind of medicine or surgery. From the standpoint of the present emergency and the rapid expansion in the Richmond area this complete industrial and health service is doing a necessary job which could not have been done nearly so effectively with the medical facilities existing when it was set up.

With the present tremendous loss of physicians to the armed forces it is absolutely necessary to pool and concentrate the remaining medical manpower to cover such industrial needs. The Kaiser plan is one answer. Whether it will pay itself out during the present emergency and what will happen after the emergency when such expansions shrink gradually or rapidly, are questions that remain at present unanswered.

California Physicians' Service

California Physicians' Service, a nonprofit medical care organization sponsored by the doctors themselves through the California Medical Association, has also entered into the health care of wartime industrial employees in shipyards and other areas. All ethical licensed physicians in California, whether or not they are members of the County or State Medical Societies, are eligible for the staff of C.P.S.

The approach of C.P.S. to this problem has necessarily been different from the approach of Mr. Kaiser, particularly since there is no chance for C.P.S. ever to reach a stage where profits from its service will accrue and will be available to amortize the cost of facilities. There is also the consideration that C.P.S. is a Statewide organization dealing with numerous groups of employed persons and responsible for the health of nonwar industry employees: Mr. Kaiser, on the other hand, is concerned only with one group of employees, albeit a large one. It is also to be noted that C.P.S. could not have the resources with which to erect new hospitals, and has not considered entering the field of industrial accident services and therefore has not this rich source of income.

California Physicians' Service has contracted for the medical care of the shipyard and other industrial em-

ployees on an area basis. Outside the industrial plants its services are being rendered employees and their families residing in the Federal Housing Authority projects built around the industrial plants. C.P.S. operates a medical center in each of the housing areas it serves; staff physicians and nurses at the medical centers give immediate care to the industrial employees and their families, referring to professional members of C.P.S. in the immediate vicinity those cases requiring hospitalization, surgery or more extensive medical care. In each case the local county medical society has consented to this arrangement and a local medical advisory committee has been established.

The Federal Public Housing Authority adds the monthly charge for C.P.S. services to the rental of the housing units and turns over these collections to C.P.S.

When and if a profit should accrue from C.P.S. services in the housing areas, such a profit must be returned to the subscribing employees and their families in the form of either reduced fees or increased services.

The cost of hospitalization is included in the C.P.S. fee.

Procurement and Assignment Service

Procurement and Assignment Service has been brought into the picture through its responsibility to civilian and industrial populations in preventing too great a loss of physicians to the military forces, and in causing proper redistribution and reallocation of physicians to areas where needed.

The one problem of Procurement and Assignment Service in this matter is the problem of meeting military quotas and at the same time directing to essential industrial organizations or to areas which are short of doctors, those physicians who cannot qualify for military service but who can give medical care to the civilian population. In its reallocation program Procurement and Assignment Service operates as an advisory body only; it has no authority to order any physician to change his location.

Early in its existence in California, Procurement and Assignment Service became aware of the building up by Mr. Kaiser and Dr. Garfield of a staff of physicians for both the industrial and nonindustrial medical care of Kaiser employees. The Kaiser staff of some thirty physicians (early in 1942), represented a group of young men, all but two of whom were definitely of military age.

A review of the Kaiser medical staff showed that practically every one of the thirty physicians should be declared "available for military service" because of his age; at the same time, Procurement and Assignment Service had no intention or desire to break up an established staff which was caring for an important segment of the industrial population.

Complaints had been heard from the medical profession that the Kaiser staff was practising "corporate medicine," that Dr. Garfield had resorted to "piracy" in hiring his physicians, that the whole operation was an unethical one, that doctors eligible for military service were being offered sanctuary and protection from Selective Service. Procurement and Assignment Service took the attitude, however, that its function had nothing to do with ethics and that its approach to the problem must be from the point of view of the distribution of physicians between military and civilian agencies.

At the same time, Procurement and Assignment Service put Dr. Garfield on notice that his staff members were vulnerable to induction into the Army by Selective Service because of their low average age. This warning was given for the protection of the staff, to obviate the disruption that might occur if a large part of the staff was classified 1-A by local draft boards and forced into military service.

On the basis of the above reasoning, a program was worked out whereby Dr. Garfield would clear through Procurement and Assignment Service any physicians who were under consideration for employment on his staff. It was understood that those physicians who otherwise would be available for military service were not to be employed by Dr. Garfield except for a temporary period, while they awaited the issuance of their commissions and orders for active duty.

A second part of this program called for the replacement of any four young staff members every ninety days; replacements were to be by physicians over military age or physically disqualified and rejected for military service. Procurement and Assignment Service agreed, under this program, to declare "essential" the remaining members of the Garfield staff until the time for replacement of each staff member should come up.

This program was put into operation. Procurement and Assignment Service has referred to Dr. Garfield no less than 25 physicians who are either too old for military service or have been rejected by the Army. Some of these have been acceptable to Dr. Garfield and have been employed by him; some have been unable to perform the medical duties with satisfaction. Nine of the former members of the Garfield staff have been accepted for military duty and have been replaced by other physicians. The program is somewhat behind schedule at present because Dr. Garfield found it necessary shortly after the start of the program to increase his staff to care for the increasing number of employees who have signed up for the plan, and to cover the expanding program of the shipyards. To accommodate this larger group of employees a 75-bed addition is being built onto the Permanente Hospital in Oakland; priorities for building materials were secured by the Maritime Commission on the ground that service was being rendered to employees of a Commission shipyard.

Today, from the point of view of Procurement and Assignment Service, the Permanente Foundation is rendering an excellent medical service to Kaiser employees. California Physicians' Service is likewise rendering an excellent health service to industrial employees and their families in the defense housing areas. The problem of Procurement and Assignment Service now is to see to it that there is not an overlapping, a duplication, of medical care facilities.

Questions Needing Answers

In the case of Richmond, can the Kaiser employees receive adequate medical and hospital care from other physicians in the vicinity?

How wide an area is the residential area of the 85,000 Kaiser employees?

How many civilian physicians are there in that area, ready, willing and able to take on the private medical care of these employees and their families?

Is Dr. Garfield going to expand his plan to include the families of employees? So far he has not done so but it is known that Mr. Kaiser has offered such coverage on previous construction projects and is likely to do so again.

Is Dr. Garfield going to expand his plan of employing civilian physicians on a part-time basis to give medical care to employees who live outside the reasonable service area around the Permanente Hospital in Oakland? He has already employed one San Francisco physician to make house calls.

Will California Physicians' Service and Dr. Garfield

be able to work out a joint program of rendering medical care to shipyard workers and their families?

What solution will be reached where the shipyard employee is paying 50 cents a week for the Kaiser medical service and finds that by living in a Federal Housing Authority housing project he is getting full medical care from C.P.S. for himself and his family? How will the overlapping of medical services in such a case be eliminated for the conservation of medical resources?

Will there be a further overlapping of medical services if Mr. Kaiser's suggestion of industry sponsoring medical foundations is generally followed on a statewide or nationwide scale?

These are some of the problems of today in regard to the Kaiser service. Entirely aside from considerations of ethical medicine, these problems exist as economic factors in the efficient distribution of medical resources. With military demands for physicians rising higher every day, with industrial employees increasing in number, with the need for a scientific utilization of all medical resources in order to make a little bit of material go a long way, these questions demand an answer.

Bit by bit, these questions are being answered by Procurement and Assignment Service and by others. Little by little the problems are being clarified, although much remains to be done before the situation will be entirely straightened out.

One thing, however, remains certain. Whatever solution to this problem is finally worked out, it must be along lines which will permit the most efficient use possible of all medical manpower.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals—For Colleagues in Military Service:

In this issue appears editorial comment on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

This notice will appear in this department every month.

If you have not read the editorial outline of the plan in the September issue, you are urged to do so.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

OFFICIAL NOTICE: IMPORTANT

(COPY)

Office for Emergency Management

WAR MANPOWER COMMISSION

Procurement and Assignment Service for Physicians, Dentists, and Veterinarians

Washington, D. C., November 15, 1942.

Dr. George H. Kress, Editor,
450 Sutter St.,
San Francisco, California.

Dear Doctor Kress:

The Directing Board of the Procurement and Assignment Service suggests that you publish the following statement in some prominent position of your OFFICIAL JOURNAL. The Board deeply appreciates the support, help, and coöperation always received from you:

"It is of the utmost importance that the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, immediately has the name of any doctor who really is willing to be dislocated for service, either in industry or in over-populated areas, and who has not been declared essential to his present locality.

"This is necessary if the medical profession is to be able to meet these needs adequately and promptly.

"We urgently request that any physician over the age of 45 who wishes to participate in the war effort send in his name to the State Chairman for the Procurement and Assignment Service in his State."

Sincerely yours,
(Signed) FRANK H. LAHEY, M.D.
Chairman, Directing Board.

New Method of Blood Transfusion

A new method of blood transfusion promises more effective treatment for men wounded on the fighting fronts, the journal of the American Medical Association recently announced.

The journal said the discovery that albumin in blood plasma (the liquid part) could be injected in more concentrated form than whole plasma provided "a new method of great effectiveness for combating shock from injuries, hemorrhage and burns."

The method was said to be particularly important for treating wounded on the battlefield to reduce the mortality from shock. Doctors using the albumin serum would need it in quantities only one-fifth as large as those required if whole plasma were used, the journal said. Hence its use would facilitate shipping, storage and administration.

California P. and A. Service

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, MC, at room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

Life Insurance for Physicians in Service

A physician who enters the service would naturally ascertain the status of his life insurance policies. He should first find out from a perusal of his policies in force whether they have a war risk exclusion clause. Policies written since the fall of 1941 contain such clauses.

Some physicians cannot maintain their life insurance programs while in the service without borrowing. Physicians should know that according to the Soldiers and Sailors Civil Relief Act of 1940 those in service can obtain a moratorium on premiums on life insurance policies not in excess of $5,000 taken out before October 17, 1940, the date of the approved act.

In order to take advantage of this moratorium a Veterans Administration Insurance Form No. 380 should be filled out and sent to the insurance company and a copy to the Veterans Administration. The Veterans Administration will issue a certificate of the U. S. Treasury to the insurance company to cover all deferred premiums.

As in World War I a man in service may take out a government term policy which will terminate in five years unless converted before the end of that period. This policy makes no provision for total or permanent disability as in 1917, but does provide for waiving of payment of premiums during continued total disability.

It is perhaps unnecessary to advise physicians to apply for a government life insurance policy on entering service, to take effect immediately.

Revised Instructions for Field Casualty and Ambulance Units of the Emergency Medical Service

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

Circular: Medical Series No. 23

To: Regional Directors and Regional Medical Officers.
FROM: JAMES M. LANDIS, *Director.*
DR. GEORGE BAEHR, *Chief Medical Officer.*

Because of the diminishing supply of civilian physicians and nurses and the growing necessity to conserve manpower, the following economies in the organization and operation of field units of the Emergency Medical Service are to be recommended to all State and local Chiefs of Emergency Medical Service for adoption:

1. *Mobile Medical Teams.*—Emergency Medical Field Units are to be composed of mobile medical teams and no longer of squads or groups of teams. Each mobile medical team is to consist, as heretofore, of one physician, one nurse, and two auxiliaries.

2. *Express Parties.*—Immediately upon receiving an air raid warden's report of a bombing incident with casualties, the Control Center will dispatch only one Express Party to each major incident. An Express Party will consist of one Rescue Team, one Mobile Medical Team, one ambulance, and perhaps one passenger car or station wagon.

3. *Reserves.*—Such an Express Party will usually be sufficient to handle a major incident or a group of neighboring minor incidents with casualties. Additional medical and rescue personnel, ambulances, and passenger cars for sitting cases should be held in reserve and should be dispatched by the Control Center only upon subsequent request of the incident physician (head of the mobile medical team) or of the incident officer at the scene.

4. *Reduction in Movement and Use of Medical Personnel.*—Mass air raids have occurred chiefly, although not exclusively, at night; both night and day raids are now usually sudden and intense. As protection against a sudden and unexpected attack by the enemy, every hospital having interns or residents is urged to have at least one or more mobile medical teams constantly on call so as to be ready to respond promptly to the order of the Control Center. Most alarms are not followed by an enemy attack; the availability of a few mobile teams at each hospital will make it unnecessary in most cities to disturb the depleted and overworked medical profession by requring them to mobilize at casualty stations throughout the city on every alert. Moreover, the first line mobile medical teams of hospitals also need not be disturbed until medical service is needed at an incident where casualties have been reported. Practicing physicians of the neighborhood should be mobilized to relieve the primary mobile team when there is a continuing need for field services at the incident, or when multiple or large incidents make it desirable to activate a casualty station for the care of the slightly injured. Conservation of medical personnel in this manner will, from now on, become increasingly important.

5. *Reduction in Number of Casualty Stations.*—Conservation of emergency medical service personnel can also be accomplished by reducing the number of casualty stations which must be equipped and staffed. British experience over three years indicates that most cities do not require more than one casualty station for each 25,000 persons and that they need not be nearer than a mile apart. Casualty stations for the temporary care of minor casualties are required at or near every hospital. They are also required in parts of a city a mile or more from a hospital and in sections which are geographically isolated. Every community is requested to reëxamine its casualty stations in the light of these requirements and to eliminate all unnecessary locations.

6. *Economy in the Use of Casualty Stations.*—Casualty stations need not be activated in areas where no casualties have been reported. A mobile medical team should always be available at hospitals to activate its casualty station when necessary. A mobile medical team should be dispatched or assembled at casualty stations near incidents only when casualties have been reported in that vicinity.

The mobile team for a casualty station located at a hospital is, therefore, best derived from the hospital; a mobile team for emergency service at casualty stations remote from hospitals should be derived either from a hospital, if within three miles, or from the physicians, nurses, and auxiliaries residing in the neighborhood if more than three miles away or otherwise geographically isolated.

7. *Central Control.*—The Chief of Emergency Medical Service or his deputy at the Control Center will keep a record of all hospital mobile teams and ambulances in his district and of physicians, nurses, and auxiliaries living in the vicinity of each casualty station, who are on call for emergency service. He will determine when to dispatch a mobile medical team from a hospital to an incident or to activate community medical personnel for service at an incident or casualty station.

8. *Elimination of Advanced First Aid Posts.*—All fixed first aid posts can be eliminated. Experience has shown that under the conditions of darkness, confusion, and dirt that exist at air raid incidents, it is rarely necessary or even possible to establish a temporary first aid post. In the darkness and dirt it is impossible to do much more for air raid casualties on the spot than cover their wounds, control hemorrhage, apply a simple splint, and administer morphine before they are removed to the hospital. Most of this work has already been done by rescue workers and the incident physician by the time the casualty is extricated. Only at a large incident with many casualties may it be desirable to esablish a first

aid post at an appropriate protected site. Even under these circumstances, it should be used as a base of operations for medical personnel rather than a place where severely injured casualties are brought for treatment.

9. *Rescue Units.*—Services of Stretcher teams are required at hospitals for unloading of ambulances. Stretcher teams (and so-called first aid parties) are not required in the field, for whatever first aid is possible at incidents is done by the trained rescue workers under the direction of the incident doctor. To conserve manpower, stretcher teams may be disbanded as soon as the rescue teams have been organized and trained, or they may be transferred to the rescue service. The equipment of a rescue team will hereafter include four stretchers. An intensive training program for rescue workers will be announced shortly.

10. *Ambulance Units.*—To reduce the movement of vehicles during an air raid, to economize in driver personnel, and to expedite the transport of large numbers of serious casualties from the incidents to hospitals, as many ambulances as possible should be remodeled so as to enable them to carry four stretchers. The use of one- and two-stretcher vehicles greatly delays the movement of large numbers of casualties to hospitals and may result in needless loss of life. To provide adequate transportation of casualties in mass air raids, exposed cities in the target areas require at least one four-stretcher ambulance for every 10,000 persons, depending upon the location of hospitals and the distances to be covered, and half that number of passenger cars or station wagons for sitting cases. Specifications for the conversion of used cars into four-stretcher ambulances will be provided by the Medical Division, United States Office of Civilian Defense.

11. *Ambulance Depots.*—To be immediately available at all times, four-stretcher ambulances and passenger cars (sedans or station wagons) should be parked at hospitals, where drivers are always on duty, or else grouped in ambulance depots located at garages in various parts of the town. Only persons residing in or living in the vicinity of the hospitals or ambulance depots should be assigned as drivers of the vehicles.

12. *Interhospital Ambulance Units.*—An additional number of large vehicles such as busses should be promptly available day and night for the simultaneous exacuation of hospitals during an air raid. In heavy air raids it has been necessary to move as many patients from evacuated Casualty Receiving Hospitals to peripheral or Emergency Base Hospitals as from incidents to hospitals within the city. In exposed cities in the target zone, it should be possible to evacuate all patients from a hospital in two or at the most three hours without utilizing the ambulance transportation of the field casualty service.

Doctor Draft for Civilians Mapped

Government officials, on December 15th, brought forward a program for relieving the "doctor shortage" in distressed war areas and warned that physicians and dentists might have to be drafted and assigned to localities where the shortage is acute.

Meanwhile, Dr. Maxwell Lapham, executive officer of the Procurement and Assignment Service of the War Manpower Commission (WMC), announced that a plan has been agreed upon under which 11,455 doctors will be called into the armed services in 1943, leaving 80,000 physicians to take care of the home front.

One For Each 1,500

Doctor Lapham made the announcement at a public hearing by a Senate Education and Labor Subcommittee considering the manpower problem.

He explained that 80,000 physicians would effect a ratio of one for approximately every 1,500 persons. This, it was testified, is regarded as the outer limit of safety from the standpoint of public health.

Dr. Joseph Mountin, Assistant Surgeon General, told the subcommittee that doctors and dentists may have to be drafted and assigned to distressed war areas where the doctor ratio sometimes is one to 5,000. Doctor Lapham agreed that this step might have to be taken.

Both officials, however, favored a plan under which doctors, dentists and nurses would be employed by the United States Public Health Service and sent to war centers where the need is greatest.

Funds For Hiring

Doctor Mountin proposed that Congress start the program off by appropriating $5,000,000 to enable the Public Health Service to hire 1,000 physicians, dentists and nurses and place them where they would be most urgently needed. This program, he intimated, probably will have to be enlarged after it has been put into operation.

"I think it should be given a trial," he declared, "although the compulsory selection and redistribution of physicians may be needed eventually."

Earlier, Col. George Baehr, chief medical officer of Office of Civilian Defense (OCD), suggested to the subcommittee that physicians be "drafted" if necessary, for service in communities where a dangerous doctor shortage exists.

"In many areas," he said, "the ratio of physicians to the population has dropped below a safe level."

Proposes Method

Colonel Baehr proposed that some redistribution of physicians be carried out by State authorities or by the medical profession. If this cannot be done, he declared, "some Federal agency should have the responsibility of providing medical personnel so that the people in the community will not be left unprotected."

He said that recommendations by Federal medical authorities for allocation of critical materials to build hospitals to meet possible bombing raids or other war casualties had been turned down by the War Production Board (WPB).

Doctor Mountin testified that the Public Health Service had used its own funds to send a certain number of doctors and dentists to war areas where the need had become extreme. . . .

Civilian Medical Needs Being Met

While a critical shortage of doctors may prevail in some war plants and shipyards because of the abnormal influx of workers and military service calls, the average civilian medical situation is not yet acute and needs are being met, Dr. L. R. Chandler, dean of Stanford University School of Medicine, said at a recent conference.

Speaking on the medical manpower situation, Dr. Chandler stated 80 per cent of illnesses are of a minor nature, such as colds, smashed fingers or poison oak poisoning and can be handled adequately in doctors' offices. It is the other 20 per cent that concern physicians most, he said, because they may end in death or disability.

Dr. Chandler said adoption of continuous training programs by most medical schools will result in graduation of 21,000 physicians in the next three years instead of the usual 15,000 for the same period.

Asserts Half of Medical Practitioners to Serve in War

Dr. Dallas B. Phemister, Chairman of the department of surgery in the medical school of the Univer-

sity of Chicago, said in an address here recently that one-half of the active medical profession will be called into service when our fighting forces are doubled and more than 30,000 physicians are now required to treat the five million men in the armed forces.

Dr. Phemister said there are 150,000 actively practicing physicians in the United States, or one for each 850 persons. During the war the army requires one physician for every 166 soldiers and the navy requires one for every 154 sailors.

Highest Percentage of Doctors

"Our army has a higher percentage of physicians than that of any other country," Dr. Phemister said, "but we have a higher percentage of physicians than any other country. Russia has one physician for every 5,000 persons, while China has one for about every 50,000 persons.

"Physicians who remain in civil service have a heavier burden to bear, not only because of the enlistment of their colleagues, but to increased work in connection with war production, increased accidents among unskilled workers, and increases in occupational and infectious diseases. The government is planning to utilize some of the immigrant physicians for the care of war workers. No more commissions in the medical corps are being issued to them, which probably means that spies have been detected in their midst."

Diseases Vary with Locations

Dr. Phemister said that there was an average of seven cases of venereal disease per thousand men weekly and that its presence varied greatly with the location of the troops. . . .

Office of Civilian Defense
Washington, D. C.
(copy)

Plasma for Civilian Defense

The Medical Division of the Office of Civilian Defense and the United States Public Health Service report the current status of the blood plasma program which was initiated in the early spring.

The report indicates that 130 hospitals have now received grants-in-aid and are preparing reserves of plasma to total at least 63,130 units. In addition to this reserve, 27,500 units of frozen plasma have been obtained through the Army and Navy from blood collected by the American Red Cross. This supply has been distributed. The Medical Division has also procured 37,500 units of dried plasma from blood collected by the American Red Cross, and this supply is in process of distribution.

The total reserve, which is largely concentrated in the 300 mile coastal target areas, will be 126,630 units for treatment of casualties resulting from enemy action. In addition, 1,250 units are in Puerto Rico and 250 in Alaska.

In addition to these sources of plasma, the Red Cross is distributing to target areas 5,000 units which will be available to the Office of Civilian Defense for treatment of civilian casualties resulting from enemy action. Many hospitals which have not received grants under the OCD-USPHS program are also preparing plasma reserves which total approximately 50,000 units.

Plasma required for the treatment of war-related injuries may be obtained by any community through its Chief of Emergency Medical Service. To meet such emergencies, plasma may be transferred: (1) within a State by the State Chief of Emergency Medical Service; (2) within a Region by the Regional Medical Officer; and (3) from one Region to another by the Medical Division, U. S. Office of Civilian Defense.

Courses for Gas Specialists

A new five-day gas specialist course for persons responsible for the organization of gas defense in the target areas will be presented in the six War Department Civilian Protection Schools conducted on behalf of and in collaboration with the U. S. Office of Civilian Defense, it was announced in Operations Letter No. 89, issued November 14. . . .

The first session of the gas specialists' course will be at Amherst College, Amherst, Massachusetts, November 29 through December 4. The course was offered December 13-18, inclusive, at the other War Department Civilian Protection Schools at Stanford University, Palo Alto, California, and Occidental College, Los Angeles. . . .

Presentation of the specialized course dealing with gas defense is part of a new plan of instruction in the War Department Civilian Protection Schools. The ten-day general course formerly given by the schools was discontinued with the session of November 1-11, and the new plan of specialized courses to be given in five days will be instituted. The other courses cover plant protection, basic civilian protection and instruction for staff members. . . .

Inasmuch as the Medical Division of the Office of Civilian Defense is responsible through its gas protection section for the administrative and technical organization of the gas program, responsibility for recruitment of students for the gas specialists' course was delegated to the Regional Medical Officers and the Regional Sanitary Engineers.

New Method of Administering Morphine

Because of the critical shortage of tin, the U. S. Office of Civilian Defense has been unable to procure syrettes for administration of morphine by physicians of Emergency Medical Service. To meet this serious difficulty, a new device using glass and plastic has been developed.

This device consists of a small, sealed-glass ampule containing ¼ gr. or ½ gr. of morphine in solution. This solution is under sufficient pressure to eject the entire contents. A piece of transparent plastic tubing encloses the neck of the ampule and connects it to the hub of the needle. The shaft of the needle is enclosed in a small glass tube, to which is attached a stylet. At the hub of the needle within the plastic tube is a small filter.

Following is the method of using the ampule:

1. The body of the ampule is grasped in the right hand.

2. The glass tube protecting the needle is withdrawn by a twisting and pulling movement of the fingers of the left hand.

3. With the needle pointing down and the body of the ampule vertical to the skin, the needle is inserted by jabbing it under the skin.

4. When the needle is in place, and with the ampule vertical to the skin, pressure is exerted with the thumb and two fingers on the plastic tubing to break the neck of the ampule. It is important that the ampule be held vertical to the skin, in order that morphine may not be lost by improper technique.

5. The pressure within the ampule ejects the contents. The filter prevents glass splinters from clogging the needle.

6. When the ampule is empty, the needle is withdrawn and the whole device is discarded.

First Aid Training No Longer Required for Staff Units in Citizens Defense Corps

Members of staff units of the U. S. Citizens Defense Corps are no longer required to acquire ten hours of

training in first aid, the U. S. Office of Civilian Defense has announced. It was pointed out that members of staff units would be employed in the headquarters of the Citizens Defense Corps rather than at the scene of air raid emergencies.

Air raid wardens, auxiliary police, auxiliary firemen, decontamination squads, messengers and members of the drivers corps are still required to have at least ten hours of first aid training. Nurses' Aides are required to take the regular first aid instruction in addition to their specified training given by the American Red Cross in connection with approved hospitals. The Medical Corps, a professional group, has special training as directed by the Medical Division of OCD.

Provision of Day Care for Children of Working Mothers

Committees or subcommittees charged with the provision of day care for the children of working mothers should be appointed by all State Defense Councils and by all local Defense councils in areas where day care is a problem, James M. Landis, Director of the U. S. Office of Civilian Defense, urged in Operations Letter No. 79, issued recently. It was pointed out that 5,000,000 women may be needed in industry by the end of 1943.

The State committee should be composed of representatives of the State departments of welfare, health, education, the U. S. Employment Service, the Works Projects Administration, organized labor, employers and other agencies and organizations concerned with child welfare in the State. The local committee should be composed of the local departments of health, welfare, education and health, the employment service, the Works Projects Administration, organized labor, employers, the local housing agency, and other agencies and organizations concerned with the welfare of children in the community.

State Defense Council committees should promote, coördinate and plan the State day-care program, the Operations Letter recommended. They should see that professional service is made available to local communities where day care is a problem, provide local committees with specific instructions and see that all resources—Federal, State and local—are focused on the problem in critical areas.

The task of the local committee is to bring to bear every available local resource, stimulating public and private agencies and organizations to take steps toward an adequate solution of the problem. It should find out the nature and extent of the need for day care; it should explore all possible types of care for children, and it should see that volunteers in child care are recruited, properly trained and effectively used.

Federal assistance for day care may be obtained from several sources. The Office of Defense Health and Welfare Services has funds which may be made available for State and local administrative and supervisory personnel in the field of day care. These funds will be allocated to State departments of welfare and education only after approval of a State plan by a committee of the State Defense Council. Funds may be obtained under the Lanham Act through the Federal Works Agency for operation and maintenance of day-care projects. Through allocation of funds for public schools, for instance, support may be obtained for nursery school projects. The State administrator of WPA can furnish information as to how to obtain Lanham Act funds for other types of projects. Finally, the Works Projects Administration has been authorized to spend $6,000,000 in 1942-1943 in the operation of day nurseries or nursery schools for children of employed mothers.

The Operations Letter concludes with instructions to Regional Offices of Civilian Defense to look into the day care problem in their Regions immediately, reviewing the extent and efficiency of the existing committees, distributing informative literature and seeking out particular problems such as lack of facilities and funds, lack of coöperation among agencies and any other matters that may be impeding the program.

Federal Financing of Transportation to Emergency Base Hospitals

Federal financing of transportation necessary in evacuating casualties and other hospitalized sick to Emergency Base Hospitals can be accomplished only through State evacuation authorities, Dr. George Baehr, Chief Medical Officer of the Office of Civilian Defense, points out in a circular (Medical Series No. 22), prepared for officials of the Emergency Medical Service. . . .

New Bulletin on Sanitation

Maintenance of sewer service in bombed areas has been one of the major difficulties confronting municipal authorities in cities under enemy attack. To assist American municipal officials and defense councils in planning for emergencies and for the restoration of normal service following damage resulting from enemy action, the sanitary engineering section of the Medical Division of the Office of Civilian Defense has issued its second sanitary engineering bulletin, "Municipal Sanitation Under War Conditions." . . .

Civilian Defense Plans for Mortuary Service

The Medical Division of the Office of Civilian Defense has issued "Medical Division Bulletin No. 5, Emergency Mortuary Services," presenting plans for the organization of this essential part of the casualty services.

The bulletin suggests that the local Chief of Emergency Medical Service work in coöperation with the medical examiner or coroner, the chief of police, the health officer and representatives of the private funeral directors and cemeteries. . . .

Military Clippings—Some news items of a military nature from the daily press follow:

McNutt Outlines America's Manpower Program for 1943

Addition of 2,500,000 Workers to Bring Over-all Total to 62,500,000 at War Tasks Held Necessary

By Paul V. McNutt, War Manpower Commission Chairman

(Written for the United Press)

Washington, Dec. 28.—Two manpower tasks face the United States in 1943:

First, the replacement of men being drawn in ever-increasing numbers into the armed forces. The second is the addition of more than 2,500,000 workers which will bring the total force to an all-time high of 62,500,000 workers, including the armed forces.

To meet these objectives, millions must go to work who never before entered the labor market.

What to Expect

A few of the developments to be expected in the coming months may be summed up as follows:

1. New millions of women will be added to the working force.

2. Industry will add to its rolls millions who five years ago it might have rejected for a variety of reasons such as age, sex, color, or minor physical handicaps.

3. There will be an acceleration of industrial training programs designed to facilitate the use of new and heretofore inexperienced workers.

Protect Rights

4. Labor and management in hundreds of communities and industries will work out plans for controlling hiring practices and channeling the right workers to the right war jobs.

5. These agreements will include provisions for protecting reëmployment rights and seniority rights in order

to stimulate the transfer of workers from civilian industries to war work.—Los Angeles *Times*, December 29.

* * *

Navy Hospital Commissioned

New Institution Located on Bixby Rancho, Near Long Beach, California

"For those who have borne the brunt of battle," the Navy's new $3,000,000 hospital on 89 acres of the old Bixby Rancho, near Long Beach, California, was commissioned yesterday, by Capt. Schuyler F. Heim, commanding officer of the San Pedro Naval Operating Base.

Today the first of the institution's patients will be transferred from outlying hospitals.

Erected in 14 months, the hospital is said to be the finest structure of its kind in America.

"The Secretary of the Navy has delegated to me the honorable duty of placing this new naval hospital in commission," Capt. Heim said in his dedicatory speech.

"Here we have erected a haven of solace, refuge and recovery for those who have borne the brunt of battle."

The hospital now contains 300 beds, but under future plans it will be outfitted with accommodations for 1200 patients.

In command of the institution is Capt. W. Howard Michael of the Navy Medical Corps. His service during the Pearl Harbor attack earned Capt. Michael the Navy Cross and the Army's Distinguished Service Cross.—Los Angeles *Times*, December 16.

* * *

1943 Draft to Call Up More Than 3,500,000

18-19 Age Group Will Furnish Half of Men Slated for Induction During New Year

Washington, Dec. 27.—(AP.)—The New Year will bring calls to the colors for more than 3,500,000 men 18 through 37 years old, Selective Service sources estimated today, at the average rate of 250,000 to 300,000 a month.

The 18 and 19 year olds completing their registration this month will comprise perhaps half of these inductees. If the ratio maintains, then the other 1,750,000, more or less, will be childless married men, for the pool of single men 20 to 38 years old available for military service has been virtually exhausted.

Big Call Coming

The armed forces will have to attain their planned strength of 9,700,000 men below officer rank by the end of next year almost exclusively from 21,000,000 to 22,000,000 men in the 18 through 37 year bracket, and that bracket has been tapped for most of the 6,100,000 or more men now in the ranks. A strength in ranks of 7,500,000 for the Army, 1,500,000 for the Navy, 400,000 for the Marines and 300,000 for the Coast Guard is planned by January 1, 1944.

Starting next month, as a general rule, draft boards will begin calling up an accumulated pool of some 600,000 to 900,000 men now 18 or 19 years old, and each month thereafter about 100,000 more will pass their eighteenth birthdays and be subject to classification for service.

Figures Withheld

Although some of these youths will be deferred for occupation, or dependents, or as college students specializing in medical and scientific work, their availability will more than offset the addtional calls made upon men 20 through 37 by the blanket deferment of men 38 or older.

Figures showing the percentage of inductees by age groups have been withheld as a military secret since Pearl Harbor, but it is obvious that comparatively few 38 through 45 year olds had been taken despite lowering of Army physical requirements since then. Older men not only have less physical capacity, but also more claims to deferment. In the twelve months before the United States entered the war, when the top draft induction age was 35, there were only 9,821 men of 35 and 12,322 of 34 among the first 921,000 inducted.

200,000 Married Men

Exact figures on the number of childless married men to be called next year also have been kept secret, but estimates advanced during Congressional debate were that as many as 200,000 would be among this month's inductees.

Of the 17,388,000 registered under the draft at Pearl Harbor time, 10,160,000 held deferment on grounds of dependency and less than 600,000 were deferred for occupational reasons. Since then, more weight has been given to occupation and less to dependency.

Passage of legislation providing funds to dependents of service men did much to lessen dependency deferments, while executive action and legislation to insure essential industry and agriculture against disruptive drains on manpower strengthened occupational deferments.—San Francisco *Examiner*, December 28.

* * *

Death Rate of Wounded Low In Solomons

Washington, Dec. 15.—(UP.)—Rear Admiral William Chambers of the Navy Medical Corps, just returned from the South Pacific, reported today that the mortality rate among wounded evacuated from the Solomons to mobile hospitals remains below the normal expectancy.

He said the major share of credit for this situation was due to speedy evacuation of the wounded to fully staffed, well-equipped hospitals, sulfa drugs, blood plasma, tetanus toxoid and efficient doctors and hospital corps men.

Rear Admiral Ross T. McIntyre, Navy Surgeon General, reported last month that the mortality rate among wounded evacuated from the Solomons was only 1 per cent for the first 1000 men. This compared with a normal expectancy of at least 5 per cent.

Chambers did not cite statistics but he indicated that this favorable showing is continuing.

"From a medical standpoint, the situation is definitely encouraging," he said.—San Francisco *Chronicle*, December 16.

* * *

Hospitals on Front Lines Prove Value

Portable Units Show Worth in New Guinea Jungle

With American Forces in New Guinea, Dec. 22 (Delayed).—A Boston surgeon, handling his instruments as deftly as if he were still working in the Massachusetts General Hospital, saved the life of an American soldier today in a portable field hospital, hidden in the jungle a few miles from the firing line.

The surgeon was Major George Marks. His operating table was a canvas stretcher mounted on empty wooden ration boxes. His nurse was a shirtless enlisted man, who handed him instruments sterilized in water boiled over an open fire.

While Major Marks worked fast, opening the soldier's abdomen, clamping and sewing his ruptured intestines, Lieutenant Frederick Ross of Boston kept him strengthened with transfusions of plasma. The operation was performed with spinal anesthetic.

Major Marks said the badly wounded soldier arrived at the hospital three hours after a Japanese sharpshooter had hit him. If the hospital had been as far back as was usual in the last war, he probably would have died.

Captain James D. Campbell of Boston, formerly of Chicago, assisted by Lieutenant John Lambert of New York, who was trained in Boston, recently performed a delicate brain operation successfully at the same hospital.

"We requested this duty," Captain Campbell said. "We are most pleased with the Army's new portable hospitals. Doctors can do much more for wounded men when they are able to operate promptly, and the best way is to be as close as possible to the front lines."—San Francisco *News*, December 28.

* * *

'Deferment Policy Shaping'

Washington, Dec. 11.—(UP.)—President Roosevelt today appointed a special three-man committee to formulate uniform policies governing occupational deferment of Federal employees from the draft.

Mr. Roosevelt left reporters with the impression that the committee's policies might develop also into an overall guide for occupational deferments in private industry. . . .

The President said the special committee was directed to give consideration to standards for determining:

1. Whether an employee is actually performing duties which are critically essential to the war effort.

2. Whether the employee can be replaced by others who are not eligible for military service.

3. Whether the employee's skills and abilities can best be used to make his maximum contribution to the total war effort in his civilian assignment or in military service. . . .—San Francisco *News*, December 11.

* * *

There's No Need to Be a Neurotic Nellie

A congressman from New Jersey recently called up the headquarters of the government agency charged with recruiting doctors for the armed services, moaning low that a lot of the people in a town of this congressman's district were protesting that one of the doctors of this community was about to be commissioned in the navy medical corps.

The congressman's constituents, needless to say, wanted something done about it. They wanted their doctor released from having to go in the navy. If something

wasn't done about it, the town was proposing to organize a delegation of 40 people to come down to Washington and get action. It was that serious. War or no war, these people weren't going to let the nasty old Navy take their beloved doctor away from them. War or no war, 40 people were going to put a further strain on the eastern railroads' transportation jam by traveling to Washington on a perfectly unnecessary journey.

A check-up on this particular situation back in Jersey revealed these facts:

The doctor in question was and had been for some time a commissioned officer in the Naval Reserve Medical Corps. He was not only willing but anxious to get into service. He was not the community's only physician. There would be no shortage of competent medical talent in the community.

And though this doctor couldn't exactly protest to his patients because of their devotion to him, his medical career in service was about to be ruined by the selfishness of a group of silly people who didn't want any other doctor to move into the community because they were afraid that after the war was over their old doctor might not come back.

Gave It Up

In the end, the delegation of 40 was persuaded not to come to Washington, and it looks as though the popular young doctor will go into service whether his patients want him to or not.

This situation is dealt with in this detail and in more space than it is probably worth because it is typical of a lot of the squawks that come into the headquarters of the Procurement and Assignment Service of the War Manpower Commission, which has the job of mobilizing the country's medical strength for war.

It is really amazing how much hell one neurotic Nellie can raise when she starts out to make a nuisance of herself, but the fact is that when a lot of the doctor-shortage scares are investigated they can be traced down to the individual head and bellyaches of people who think there is only one doctor in the world for their case.

How much choice do you suppose the soldier or sailor with half a leg or an arm shot off has in the selection of the surgeon who attends him? The answer is that he's glad to get whatever sawbones or pill dispenser happens along. . . . And as for Army medication, it has long survived on a reputation for administering shots, iodine or salts for all ailments, so if the armed services can survive on such treatment, civilians should be able to get along.

Stretch It Out

All this is not set down to minimize the fact that there are genuine shortages of doctors in some areas, and that these shortages may be caused by heavy recruitment of physicians. You can't slap 50,000 or 150,000 workers into a new war production area that two years ago was a great open space and expect them to get along without doctors.

But the answer is that civilian medical practice will have to be stretched farther. Specialists will have to give up their exclusive fields and become just plain old-fashioned family doctors. And patients will have to learn to adjust their illnesses.

Quit getting the doctor out in the middle of the night. You call at his office instead of making him call at your bed of pain.

There are so many sides to this question of the doctor shortage, however, that the subject will have to run into two more installments.—Visalia *Times-Delta,* December 2.

* * *

Take Cold or Bruise to Doctor; Don't Call Him to Your Home

Palo Alto.—(AP.)—"The hours of every civilian doctor are budgeted," Dr. L. R. Chandler of Stanford University said yesterday, and "patients suffering from poison oak will just have to wait for the patient who has coronary occlusion."

Dr. Chandler's comment was made in a review of civilian medical needs at a time when the armed forces are increasing their demand on the services of physicians and surgeons.

Speaking at a luncheon meeting of the Stanford Associates, the dean of the university's medical school said that although a critical shortage of doctors existed in some areas crowded by abnormal concentrations of war workers, for the most part civilians still are receiving all necessary medical care.

In time, Dr. Chandler pointed out, the present program of accelerated training adopted by most of the country's medical schools will bring results in the graduation of 50 per cent more qualified practitioners each year.

Until then, he suggested, the situation could be kept in hand if civilians would make a point of taking their minor afflictions, such as colds or smashed fingers, to doctor's offices for treatment. Eighty per cent of the cases on which physicians are called are of this secondary nature, he estimated.—Sacramento *Union,* December 9.

* * *

Misfits Are New Menace to Country

Chicago, Dec. 5.—(UP.)—Capt. David J. Flicker, M. D., said today that "tens of thousands" of Army inductees mentally and nervously unfit for service are being taken into the Army because of insufficient time allowed medical interviewers at induction boards.

Flicker, writing in *War Medicine,* published by the American Medical Association, estimated that 5 to 10 per cent of draft age men have psychiatric disorders which would cause them to break down under military life. Once these men become psychiatric war casualties, he said, the country must spend millions of dollars for their hospitalization and compensation.

At his post, Camp Blanding, Fla., one of the country's most active induction centers, Flicker said psychiatrists have only two or three minute interviews with inductees and no individual medical histories to detect these disorders.

To correct the situation, Flicker suggested: obtaining psychiatric histories from local selective service boards, schools and social service agencies, allowing a minimum of five minutes per interview and obtainlng assistance from psychiatrists at State hospitals and institutions.—Hanford *Journal,* December 6.

COMMITTEE ON SCIENTIFIC WORK

OFFICIAL NOTICES: ANNUAL SESSION

Decision to hold a two-day, streamlined Annual Session of the California Medical Association in Los Angeles, Sunday, May 2nd—Monday, May 3rd, 1943, received comment in the December issue of California and Western Medicine, on page 341.

Because of existing difficulties regarding transportation and to reassure members concerning rail and air schedules to Los Angeles, the information noted below is appended.

As stated in California and Western Medicine, in December, the headquarters will be at Hotel Biltmore on Olive, between Fifth and Sixth Streets. Preliminary information concerning hotels appears below. In due course, other announcements will be made.

Members of the Association who have scientific papers in mind should promptly communicate with the proper Section Secretary. The list of Section Officers appears in each issue of California and Western Medicine, on advertising page 6.

* * *

Transportation Information

Following schedules are subject to change.

Southern Pacific

San Francisco

Name of Train	*Number*	*Leave San Francisco*	*Arrive Los Angeles*
		Coast Route	
Morning Daylight	98	8:15 a. m.	6:00 p. m.
Coaster	70	6:30 p. m.	8:30 a. m.
Lark	76	9:00 p. m.	9:00 a. m.
		Valley Route	
Owl	26	6:00 p. m.	8:35 a. m.
San Joaquin Daylight	52	7:30 a. m.	8:00 p. m.

OAKLAND

		Leave Oakland	Arrive Los Angeles
Owl	26	6:32 p. m.	8:35 a. m.
Lark	74-76	8:00 p. m.	9:00 a. m.

SACRAMENTO

		Leave Sacramento	Arrive Los Angeles
West Coast	15-60	8:00 p. m.	9:10 a. m.

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United Airlines

United Airlines at the present time has a schedule showing nine flights daily between San Francisco and Los Angeles.

Hours of departure from San Francisco are as follows: 3:05 a.m., 6:45 a.m., 8:30 a.m., 11:00 a.m., 2:00 p.m., 4:00 p.m., 4:45 p.m., 6:15 p.m., and 8:30 p.m.

Hours of arrival in Los Angeles of the above airships are: 5:46 a.m., 9:15 a.m., 10:30 a.m., 1:38 p.m., 4:00 p.m., 6:10 p.m., 7:26 p.m., 8:25 p.m., and 10:40 p.m.

Los Angeles departure schedule to San Francisco follows: 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:45 p.m., 2:15 p.m., 5:00 p.m., 6:45 p.m., 8:00 p.m., and 11:30 p.m.

The round trip fare between San Francisco and Los Angeles is $37.90—one way $18.95.

Reservations should be made in ample time. The San Francisco office of United Airlines is 400 Post Street.

United Airlines also flies airships between Los Angeles and San Diego, the round trip being $12.00—one way $6.00.

* * *

Santa Fe Railroad

San Francisco The Santa Fe at the present time has a schedule of 9 trains daily between San Francisco-Oakland and Los Angeles. (All San Francisco trains transfer to bus, at Bakersfield.)

Hours of departure from San Francisco are as follows: 9:00 a.m. (Streamliner), 3:00 p.m., 6:00 p.m. (Streamliner), and 11:30 p.m.

Hours of arrival in Los Angeles of the above trains are: 7:05 p.m., 4:10 a.m., 4:10 a.m., and 1:20 p.m.

San Diego The Santa Fe has 5 trains and 11 buses between Los Angeles and San Diego daily, the round trip being $3.03 by either train or bus, one way by bus $1.98 and by train $2.18.

Hotels: Los Angeles

The official headquarters of the next Annual Session will be the Biltmore Hotel, Los Angeles. Owing to existing conditions, it is probable that the facilities of other hotels must also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, the date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Biltmore.

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
*Biltmore Hotel**, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 529 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 615 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 830 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
Monarch Hotel, 905 W. Fifth St.	(MIchigan 7311)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

* Headquarters Hotel.

* * *

BILTMORE HOTEL: HEADQUARTERS HOTEL

515 S. Olive (MIchigan 1011)

Mr. Alvin Knocke, Assistant Manager
(In charge of reservations)

Single rooms	$5.00, $5.50, $6.00, $6.50 and $7.00
Double rooms	$7.00, $7.50, $8.00, $8.50 and $9.00
Suites	$12.00, $15.00, $20.00

All rooms in the Biltmore have individual private baths, and in the case of the doubles, twin or double beds are optional.

* * *

AMBASSADOR HOTEL

3400 Wilshire Blvd. (DRexel 7011)

Mr. J. E. Benton, Manager

Single room with bath, one person	$ 5.00
Double room with bath, two persons	8.00
Twin beds	15.00
Two single rooms, bath between, two persons, each	8.00
Two double rooms, bath between, four persons, each	15.00

* * *

ALEXANDRIA HOTEL

210 W. Fifth St. (MAdison 2741)

Mr. Clayton V. Smith, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

* * *

CHAPMAN PARK HOTEL

615 S. Alexandria Ave. (FItzroy 1181)

Mr. Harry S. Ward, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

* * *

CLARK HOTEL

426 S. Hill St. (MIchigan 4121)

Mr. Beckett, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

* * *

GATES HOTEL

830 W. Sixth St. (TRinity 3931)

Mr. Vernon Peck, Manager

Single room without bath, one person	$1.50
Double room without bath, two persons, each	1.50
Single room with bath, one person	3.00
Double room with bath, two persons	4.00
Two single rooms, bath between, two persons, each	4.00
Two double rooms, bath between, four persons, each	4.00

* * *

HAYWARD HOTEL

206 W. Sixth St. (MIchigan 5151)

Mr. Russell Wagner, Manager

Single room without bath, one person	$2.00
Double room without bath, two persons, each	2.50
Single room with bath, one person	2.50
Double room with bath, two persons	3.00
Two single rooms, bath between, two persons, each	3.50

* * *

MAYFAIR HOTEL

1256 W. Seventh St. (FItzroy 4161)

Mr. H. H. Hasslinger, Manager

Single room with bath, one person	$2.75
Double room with bath, two persons	3.30

* * *

MAYFLOWER HOTEL

535 S. Grand Ave. (MIchigan 1331)

Mr. J. B. Huesman, Manager

Single room with bath, one person.....$2.75
Double room with bath, two persons..... 3.85
Connecting rooms with bath..... 3.80

ROSSLYN HOTELS

111 W. Fifth St. (MIchigan 3311)

Mr. E. S. Heckler, Manager

Single room without bath, one person.....$1.50
Double room without bath, two persons..... 2.00
Single room with bath, one person..... 2.00
Double room with bath, two persons..... 3.00

WILLIAM PENN HOTEL

2208 W. Eighth St. (EXposition 3181)

Mrs. Dawn Olson, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 2.50
With twin beds..... 3.50

TOWN HOUSE HOTEL

639 S. Commonwealth Ave. (EXposition 1234)

Mr. C. W. Gaskell, Manager

Single room with bath, one person.....$ 6.00
Double room with bath, two persons..... 7.00
Single suites with baths..... 10.00

HOTEL STILLWELL

838 S. Grand Ave. (TRinity 1151)

Mr. F. W. Morris, Manager

Single room with bath, one person.....$3.50
Double room with bath, two persons..... 4.00

SAVOY HOTEL

601 W. Sixth St. (MAdison 1411)

Mrs. Leslie Consolloy, Manager

Single room without bath, one person.....$2.00
Double room without bath, two persons..... 2.75
Single room with bath, one person..... 2.75 up
Double room with bath, two persons..... 2.75 up

CARLTON HOTEL

529 S. Figueroa St. (MIchigan 6571)

Mr. Tom Miles, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 3.00
Two double rooms, bath between, per suite..... 5.00

MONARCH HOTEL

905 W. Fifth St. (MIchigan 7311)

Mr. J. Westerbach, Manager

Single room with bath, one person.....$2.00
Double room with bath, two persons..... 3.00

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Basic Science Act — Proposition No. 3 on the November 3, 1942, Ballot. Final Figures

As a matter of final record, CALIFORNIA AND WESTERN MEDICINE is reprinting from Publication 19012 of the State of California on "Statement of Vote of the General Election of November 3, 1942," the final and official figures by counties.

It will be noted therefrom that with the exception of three counties, the measure went down to defeat, the total vote for the Basic Science Act being 584,324 and the total ballot against the proposed law being 1,132,957.

The three counties which cast more votes in favor than against were Marin (124), San Mateo (80), and San Francisco (16,770). The figures in brackets show the favorable majority in these three counties.

Detailed vote follows:

Counties	*Yes Votes*	*No Votes*
Alameda	68,160	84,638
Alpine	17	62
Amador	433	1,167
Butte	2,752	5,727
Calaveras	551	1,242
Colusa	597	1,433
Contra Costa	11,053	18,117
Del Norte	317	530
El Dorado	656	2,257
Fresno	8,526	25,652
Glenn	957	2,023
Humboldt	4,264	6,950
Imperial	1,643	3,886
Inyo	502	1,130
Kern	7,435	16,392
Kings	1,502	4,383
Lake	511	1,387
Lassen	748	1,785
Los Angeles	218,517	539,971
Madera	847	2,777
Marin	6,278	6,154
Mariposa	319	771
Mendocino	1,552	3,728
Merced	2,334	5,046
Modoc	301	920
Mono	80	274
Monterey	5,081	7,644
Napa	3,219	3,465
Nevada	1,266	2,354
Orange	9,820	27,259
Placer	1,597	4,639
Plumas	506	1,275
Riverside	6,691	16,697
Sacramento	11,108	29,942
San Benito	1,209	1,129
San Bernardino	8,957	26,541
San Diego	22,212	42,704
San Francisco	89,027	72,257
San Joaquin	6,021	19,891
San Luis Obispo	2,872	5,212
San Mateo	14,881	15,197
Santa Barbara	5,426	11,428
Santa Clara	17,935	26,601
Santa Cruz	4,404	7,035
Shasta	1,401	3,915
Sierra	140	371
Siskiyou	1,915	3,707
Solano	4,325	7,927
Sonoma	5,774	10,895
Stanislaus	4,274	11,458
Sutter	666	2,887
Tehama	779	2,329
Trinity	282	590
Tulare	4,292	11,962
Tuolumne	850	1,716
Ventura	3,723	9,497
Yolo	2,264	3,460
Yuba	555	2,566
Totals on No. 3 (Basic Science)	584,324 (Yes)	1,132,957 (No)

California Legislature to Streamline New Session

Lyon, Slated for Speakership of Assembly, Reveals Plan to Speed Up Work in 1943

Sacramento, Dec. 14.—(AP.)—Further streamlining of legislative procedure is in prospect for the fifty-fifth session, Assemblyman Charles Lyon said today in support of a prediction that the legislature may finish its work by late April or May.

The veteran Los Angeles Assemblyman, who appears to be slated for the speakership, said that a forty-day constitutional recess, instead of the usual thirty days, probably will be taken to enable the State printing plant to turn out the bills introduced at the opening session despite the reduction of its force by war demands. . . .

The plan to facilitate proceeding will include the convening of assembly sessions at 10 a. m. instead of 2 p. m., reduction of standing committees from fifty-seven to twenty-seven, with no members holding membership on more than four committees, a simplification of House rules and the holding of committee meetings from 3 p. m. to 6 p. m., and at nights instead of in the forenoon. . . .
—San Francisco *Examiner*, December 15.

CALIFORNIA LEGISLATURE: 55TH SESSION

Roster of State Senators and State Assemblymen

Much legislation related to public health work will be submitted to the Legislature now in session at Sacramento. For the convenience of C.M.A. members the Senate and Assembly rosters appear below. Addresses given are home addresses. At Sacramento, the legislators may be addressed in care of Senate or Assembly Chamber, the Capitol, Sacramento.

State Senators

(Senators from odd-numbered districts were elected in 1940)

District Number

1 Harold J. Powers (R)—Eagleville
2 Randolph Collier (R)—555 North Main Street, Yreka
3 Irwin T. Quinn (D)—First National Bank Building, Eureka
4 George Milton Biggar (R)—Covelo
5 Oliver J. Carter (D)—Carter Building, Redding
6 Charles H. Deuel (D)—273 East Sacramento Avenue, Chico
7 Jerrold L. Seawell (R)—303 Mariposa Avenue, Roseville
8 Clair Engle (D)—1010 Jackson Street, Red Bluff
9 H. E. Dillinger (D)—618 Main Street, Placerville
10 W. P. Rich (R)—Marysville
11 Frank L. Gordon (R)—Suisun
12 Herbert W. Slater (D)—800 Fourth Street, Santa Rosa
13 Thomas F. Keating (D)—Freitas Building, San Rafael
14 John F. Shelley (D)—69 Beachmont Drive, San Francisco
15 Thomas McCormack (R)—Rio Vista
16 Arthur H. Breed, Jr. (R)—315 Fifteenth Street, Oakland
17 T. H. DeLap (R)—American Trust Building, Richmond
18 Byrl R. Salsman (R)—2030 Webster Street, Palo Alto
19 John Harold Swan (D)—1133 Marian Way, Sacramento
20 Bradford S. Crittenden (R)—145 East Harding Way, Stockton
21 Harry L. Parkman (R)—934 Rosewood Drive, San Mateo
22 Hugh P. Donnelly (D)—953 Sierra Drive, Turlock
23 H. R. Judah (R)—42 Third Street, Santa Cruz
24 George J. Hatfield (R)—P. O. Box C., Newman
25 Edward H. Tickle (R)—Carmel
26 Jesse M. Mayo (R)—Angels Camp
27 R. R. Cunningham (D)—Hanford
28 Charles Brown (D)—Shoshone
29 Chris N. Jespersen (R)—Atascadero
30 Hugh M. Burns (D)—3307 Huntington Boulevard, Fresno
31 Clarence C. Ward (R)—220 La Arcada Building, Santa Barbara
32 Frank W. Mixter (R)—303 East Palm Street, Exeter
33 James J. McBride (D)—471 East Main Street, Ventura
34 Jesse R. Dorsey (R)—1028 Q Street, Bakersfield
35 Thomas H. Kuchel (R)—Bank of America Building, Anaheim
36 Ralph E. Swing (R)—Central Building, San Bernardino
37 Vacancy—Riverside County
38 Jack B. Tenney (D)—3201 West Seventy-second Street, Los Angeles
39 E. George Luckey (D)—307 West Eighth Street, Brawley
40 Ed Fletcher (R)—869 Rosecrans Boulevard, San Diego

(R) *Republican Senators* 23
(D) *Democratic Senators* 16
Vacancy 1
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State Assemblymen

District Number

1 Michael J. Burns (R)—1644 Summer Street, Eureka
2 Paul Denny (R)—Etna
3 Lloyd W. Lowrey (D)—Rumsey
4 Albert M. King (D)—Riverside Drive, Oroville
5 Ernest C. Crowley (D)—Fairfield
6 Allen G. Thurman (R)—Colfax
7 Richard H. McCollister (R)—77 Marguerite Avenue, Mill Valley
8 Chester F. Gannon (R)—3543 H Street, Sacramento
9 Earl D. Desmond (D)—2022 Twenty-second Street, Sacramento
10 Harold F. Sawallish (D)—American Trust Building, Richmond
11 Charles M. Weber (R)—219 North Sutter Street, Stockton
12 James E. Thorp (R)—Lockeford
13 Francis Dunn, Jr. (D)—1634 Sixty-ninth Avenue, Oakland
14 Randal F. Dickey (R)—3221 Thompson Avenue, Alameda
15 Bernard A. Sheridan (R)—3135 Sheffield Avenue, Oakland
16 Arthur W. Carlson (R)—12 Marlborough Court, Piedmont
17 Edward J. Carey (R)—4506A San Pablo Avenue, Emeryville
18 Gardiner Johnson (R)—765 San Luis Road, Berkeley
19 Bernard R. Brady (D)—886 Thirty-ninth Avenue, San Francisco
20 Thomas A. Maloney (R)—350 Missouri Street, San Francisco
21 Albert C. Wollenberg (R)—2748 Steiner Street, San Francisco
22 George D. Collins, Jr. (D)—1456 Union Street, San Francisco
23 William Clifton Berry (D)—3747 Twentieth Street, San Francisco
24 Edward F. O'Day (D)—1353 Church Street, San Francisco
25 Gerald P. Haggerty (D)—155 St. Elmo Way, San Francisco
26 Edward M. Gaffney (D)—2081 Fifteenth Street, San Francisco
27 Harrison W. Call (R)—Eaton Drive, Redwood City
28 Raup Miller (R)—2237 El Camino Real, Palo Alto
29 John F. Thompson (D)—Route 4, Box 299, San Jose
30 Ralph M. Brown (D)—915 Carolyn Avenue, Modesto
31 George A. Clarke (R)—Route 1, Box 105, Le Grand

32 Jacob M. Leonard (R)—470 Hawkins Street, Hollister
33 Fred Weybret (R)—Star Route, Soledad
34 J. G. Crichton (D)—752 Buckingham Way, Fresno
35 S. L. Heisinger (D)—Route 4, Box 90E, Fresno
36 C. L. Guthrie (D)—627 Mill Street, Porterville
37 Alfred W. Robertson (D)—1524 Garden Street, Santa Barbara
38 Walter J. Fourt (R)—315 Lupin Way, Ventura
39 Thomas Harold Werdel (R)—2200 Pine Street, Bakersfield
40 William H. Rosenthal (D)—409 South Boyle Avenue, Los Angeles
41 Julian Beck (D)—423 Hagar Street, San Fernando
42 Everett G. Burkhalter (D) — 11005 Morrison Street, North Hollywood
43 C. Don Field (R)—1552 Ridgeway Drive, Glendale
44 John B. Pelletier (D)—248 South Olive Street, Los Angeles
45 Thomas J. Doyle (D)—4333 Griffin Avenue, Los Angeles.
46 Glenn M. Anderson (D)—582 North Hawthorne Boulevard, Hawthorne
47 Willis Sargent (R)—300 Bellfontaine, Pasadena
48 T. Fenton Knight (R)—4850 Oakwood Avenue, La Canada
49 Lee T. Bashore (R)—250 Live Oak, Glendora
50 Thomas M. Erwin (R)—1425 South Central Avenue, El Monte
51 Elwyn S. Bennett (D)—918 South Fraser Avenue, Los Angeles
52 Jonathan J. Hollibaugh (R)—6908 Rugby Avenue, Huntington Park
53 Lothrop Smith (R)—568 North Milton Drive, San Gabriel
54 John B. Knight (R)—5224 Maywood, Eagle Rock
55 Vernon Kilpatrick (D)—1246 South Hope Street, Los Angeles
56 Ernest E. Debs (D)—2324 Teviot Street, Los Angeles
57 Franklin J. Potter (R)—3277 Primera Avenue, Hollywood
58 Frank J. Waters (R)—959 Keniston Avenue, Los Angeles
59 Charles W. Lyon (R)—604 North Oakhurst Drive, Beverly Hills
60 Jesse Randolph Kellems (R)—454 Cuesta Way, Bel Air, Los Angeles
61 Lester A. McMillan (D)—2726 Forrester Drive, Los Angeles
62 Augustus F. Hawkins (D)—220 East 46th Street, Los Angeles
63 Don A. Allen (D)—3867 Degnan Boulevard, Los Angeles
64 John C. Lyons (R)—3208 Bellevue Avenue, Los Angeles
65 John W. Evans (D)—4813 South Western Avenue, Los Angeles
66 Jack Massion (D) — 846 East Seventy-seventh Street, Los Angeles
67 Clayton A. Dills (D)—15145 South Vermont Avenue, Gardena
68 Vincent Thomas (D)—722 West Twentieth Street, San Pedro
69 Ralph C. Dills (D)—1505 North Spring Street, Compton
70 Lorne D. Middough (D)—233 Roswell Avenue, Long Beach
71 Fred N. Howser (R)—3940 Linden Avenue, Long Beach
72 R. Fred Price (R)—303 West Emporia Avenue, Ontario
73 Douglas P. Armstrong (R) — Palmetto Street, Redlands
74 Clyde A. Watson (R) — 273 North Harwood Street, Orange
75 Sam L. Collins (R)—North Cypress Avenue, Fullerton
76 Nelson S. Dilworth (R)—Route 1, Box 18, Hemet
77 Harvey E. Hastain (R)—277 West K Street, Brawley
78 Frederick H. Kraft (R)—1889 Bacon Street, San Diego
79 Kathryn T. Niehouse (R)—4889 Bancroft Street, San Diego
80 Charles W. Stream (R)—664 Del Mar Avenue, Chula Vista

(R) *Republican Assemblymen 44*
(D) *Democratic Assemblymen 36*

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CALIFORNIA'S MEDICAL PRACTICE ACT—ARE TEMPORARY LICENSES TO PRACTICE DESIRABLE?

The items which appear below are referred to in brief editorial comments which appear on page 2. ("Item A draft" was submitted by the American Federation of Medical Boards.)

Item A

A draft of proposed legislation to authorize and provide for the temporary admission to practice in the States of physicians and dentists to protect the health of the civilian population during the war emergency period.

Be it enacted . . .

Section 1. *Purpose.* A serious public emergency exists or may exist in this State because of the demands of the armed services for physicians and dentists. Coöperation on the part of the State, with certain Federal agencies, such as the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians of the War Manpower Commission is imperative, so that temporary relocation of physicians and dentists may be accomplished, to overcome acute shortages in specific localities from time to time. For the protection of the health and welfare of the people of the State, power to provide for the temporary admission to practice in the State of physicians and dentists, licensed as such outside the State, is hereby conferred upon the State Board of Medical Registration and Education* and the State Board of Dental Registration and Education* upon conditions and under regulations prescribed by them.

Section 2. *Power to provide for the temporary admission to practice medicine and dentistry in the State.* To accomplish the purpose set forth in Section 1, and notwithstanding any inconsistent provision of law, the State Boards of Registration and Education in Medicine and Dentistry* shall have power by general regulations or specific orders, to issue temporary emergency certificates to such physicians and dentists, licensed as such outside the State, as they shall find qualified to practice as such in the State during such emergency. The holder of any such temporary certificate shall be privileged during the term specified therein, unless sooner revoked, to practice his profession within the State, subject however, to all laws of the State generally applicable to the practice of such profession and to such regulations, restrictions, and area limitations as the State Boards* may make or impose as to them or any of them and their practice within the State.

* Substitute appropriate licensing agency or group existing in your State.

Item B

Statement of Principles to be recommended to the respective State Boards of Registration and Education in Medicine and Dentistry.

1. The need for relocation or assignment of physicians or dentists shall be determined by the Directing Board of the Procurement and Assignment Service with the aid of the State Committees of the Procurement and Assignment Service and other agencies and on agreement with the State Boards of Registration and Education in Medicine and Dentistry.

2. These needs shall be met as far as possible by the relocation of physicians or dentists holding licenses within the State.

3. Whenever possible needs shall be met by taking full advantage of existing provisions for reciprocity between the states and inter-state endorsement.

4. Whenever existing laws make impossible the granting of temporary certificates, state boards should recommend to the Governor and to the state legislatures the earliest possible enactment of the bill designed to make possible the utilization of physicians and dentists under temporary certification.

5. When existing measures for relocation of physicians or dentists prove inadequate State Boards of Registration and Education may request the Directing Board of the Procurement and Assignment Service to certify to them the names and qualifications of physicians and dentists who have volunteered or who may be otherwise available for relocation, at which time also such physicians or dentists may be notified that their names have been sent to the State Boards making such requests.

6. The physician or dentist who accepts relocation shall agree to assignment to the specific area in which services are required and to acceptance of a certificate which limits the duration of such service to the period of the emergency and for such additional time as the State Boards may prescribe.

7. In view of the emergency character of this action, the Committee representatives, the Directing Board of the Procurement and Assignment Service, and the Federation of State Medical Boards of the United States, recommend that fees for such certification be waived or reduced to a minimum.

* * *

Item C*

1. How soon after application will the temporary license be issued?

2. Who will pass on credentials submitted, particularly by foreign medical school graduates?

3. How many votes of the California State Board of Medical Examiners will be required to issue a temporary license? Will special Board meetings be required? Source of funds for transportation of Board members.

4. How long will be the term of the temporary license?

5. Will the holder of a temporary license be required to pay the annual tax, the same as is required of other licentiates? The State of California contributes no support from its General Fund. The Board's funds come entirely from physicians. Amount available is subsequently budgeted by other authorities.

6. What method will be employed to see that the holder:

a. Ceases practice when his temporary license expires?
b. Has kept the main office of the Board informed of any change in address or location during the period the temporary license was operative.

7. What penalty will be imposed for his failure to pay annual tax?

8. What procedure will be followed if the holder of a temporary license is guilty of unprofessional conduct?

9. What penalty will be imposed if he has secured his license based on fraudulent credentials?

10. What procedure would be followed if he secured a license based on any government credentials when the records subsequently showed him as a graduate of a "nonrecognized" school?

11. What check will be possible on the temporary licensee's diploma if issued by a so-called "diploma mill"?

12. What disposition will be made in the instance of the following:

a. Those who have failed to pass a California State Board examination?
b. Those who may have a criminal record here or elsewhere?
c. Those whose license to practice has been revoked either in California or elsewhere?
d. Those reported as engaged in narcotic irregularities in California or elsewhere?

13. How will cancellation of temporary license be enforced?

14. Attention is called to the fact that possession of medical college diploma as well as medical license, etc., are not conclusive. For cases of history of fraudulent credentials, see:

Phillips, James H., A.M.A. Jour., Sept. 12, 1942, p. 145.

Raffelson, Aaron W., A.M.A. Jour., May 24, 1941, p. 2424.

Pamphlet entitled, "Fraudulent Credentials," by Charles B. Pinkham, M. D.

* * *

Item D*

Section 1 authorizes the granting of a temporary admission to practice. This will have to be very carefully guarded lest the practice of medicine be opened to everyone, either foreign or domestic, who seeks to practice in California, whether by purchased diploma or by experience in other states. In many states, such as Texas and Oklahoma, not excepting Massachusetts, persons in the past have been licensed to practice without medical diplomas. This is similar to the procedure reported in China, where all one has to do is to announce: "I am a doctor" and proceed to practice.

Page 2 contains a draft of proposed legislation to accomplish the above mentioned "temporary licensing" and also provide for "temporary relocation" of present licentiates. Referring to the first paragraph of page 2, providing for "temporary admission to practice in the State of physicians . . . licensed as such outside the State," this opens the door to everyone licensed to practice in States and Territories of the United States and everyone licensed to practice in any foreign country. We are wondering what means will be taken to "temporarily relocate" licensed physicians and surgeons and who will pay the cost of transportation, as well as the expenses of physicians until their income is satisfactory, for instance, in the case of San Francisco physicians supposed to locate in out of the way places such as Paradise Valley, etc.

Section 2 provides for "power to provide for the temporary admission to practice medicine . . . in this State," this to be accomplished by State Boards assuming power "by general regulations or specific orders . . ." and the natural inquiry is as to who issues the orders. It certainly will not be interstate, unless the legislature passes a law to that effect. Do these "specific orders" refer to "regimentation" from headquarters in Washington, D. C.?

Section 2 provides for "temporary emergency certificates," but no mention is made as to the duration of such

* Queries in re: California Law.

* Some comments and questions which may arise on law proposed by the American Federation of State Medical Boards. See Item A for draft of the proposed law.

certificate. After the "duration," the individual who has been practicing in a locality under such a temporary certificate, will probably seek every possible aid to continue such practice and the argument will be advanced that if he was good enough to practice during the "emergency," he is certainly good enough to practice in a specific locality after the "emergency" is over. There is no doubt but that he will muster much individual legislation along that particular line. At least, past experience so indicates.

Section 2 provides that the holder of such a "temporary certificate" shall be privileged to practice within the State, "subject to all laws of the State generally applicable to the practice . . ." Phraseology such as this will cause no end to the present difficulties in law enforcement. Disciplinary action in citing temporary certificate holders will be ineffectual. Citation of violators of narcotic laws, etc., will also be ineffectual.

Paragraph 7 of the "Principles," refers to the granting of temporary certificates in the State of California on waiver or reduction to a minimum of the fee established by law. Inasmuch as the California Board of Medical Examiners exists only on the income from the fees that it collects, it would not be long before the financial condition might make further functioning impossible.

COMMITTEE ON MEDICAL ECONOMICS

Trust Conviction of Medical Body Up to High Court

Washington, Dec. 11.—(AP.)—Validity of the American Medical Association's conviction on a charge of violating the Sherman Anti-Trust law by alleged activities against a group-health organization in the District of Columbia was at issue today in arguments before the Supreme Court.

One of the disputed points was whether practicing medicine is a trade or a profession. The Sherman act prohibits combinations in "restraint of trade."

The Association and an affiliate, the Medical Society of the District of Columbia, were convicted in the United States district court here. A $2500 fine was imposed against the national organization and a $1500 fine against the local society.

Conspiracy Charged

They were accused of conspiring against Group Health Association, Inc., described as a nonprofit coöperative association of Government employees.

Thurman Arnold, assistant attorney general in charge of anti-trust law enforcement, contended in a brief filed with the court that "the conspiracy to prevent Group Health from successfully carrying on its business of furnishing medical service to members of the consuming public was a restraint of trade prohibited by the Sherman act."

Defined as Trade

"Group Health," he added, "was engaged in a large scale undertaking to provide medical service in exchange for payment of dues. This exchange of service for money is trade in the primary and most usual meaning of the word."

Seth W. Richardson, Washington attorney for the medical associations, replied that "all of the dictionaries agree that in the broadest meaning ever ascribed to trade to date it has never been understood to include the arts or the learned professions."

Judicial definitions and the legislative history of the Sherman act, he added, demonstrate "inescapably" that the word "concerns only commercial activities and excludes the learned professions."—Oakland *Tribune*, December 11.

Charity Hospitals Not Required to Contribute to Unemployment Insurance Fund, Judge Wilson Rules

In a decision which will affect all charitable hospitals throughout California, Superior Judge Emmet H. Wilson has determined that such hospitals are not employers within the meaning of the California Unemployment Insurance Act and are therefore not required to make contributions to the Unemployment Insurance Fund. The case is said to be one of first impression in California.

Excerpts from the opinion follow:

OPINION

No. 474,695

In the Superior Court of the State of California in and for the County of Los Angeles.

* * *

Seaside Memorial Hospital of Long Beach, a nonprofit corporation, Petitioner, vs. *California Employment Commission, et al.*, Respondents, and *Edith Newby Cope, et al*, Co-Respondents.

* * *

For Petitioner: Musick & Burrell and James E. Ludlam.

Amici Curiae in support of Petitioner: Orrick, Dahlquist, Neff & Herrington.

For Respondents: Earl Warren, Attorney General and John J. Dailey, Deputy Attorney General.

Of Counsel for Respondents: Maurice P. McCaffrey, Glenn V. Walls, Elizabeth Doyle, Forest M. Hill, and Doris H. Maier.

* * *

This is a mandamus proceeding brought for the purpose of requiring respondent California Employment Commission, its members and Director, hereinafter sometimes referred to jointly as "Commission," to reverse its ruling in a tax decision case wherein said Commission held that petitioner, hereinafter sometimes called "Hospital" was an employer subject to the provisions of the California Unemployment Insurance Act, and to make the following rulings: . . .

Petitioner's claim of exemption under section 7(g) of the statute. Section 7 of the California Unemployment Insurance Act provides: "The term 'employment' does not include: * * * (g) Service performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual:" (Stats. 1939, ch. 1039, p. 2850.) This language is identical with that found in section 907 (c) (7) of the Federal Social Security Act which in turn was taken verbatim from section 101 (6) of the Revenue Act of 1934. In 1939 said section 907(c)(7) became section 1607 (c) (8) of the Internal Revenue Code (26 U. S. C. A. sec. 1607, p. 402) with the addition of words not affecting or applicable to this proceeding. . . .

Petitioner's claim of exemption under section 7(g) of the statute. . . .

In order to do charity petitioner must have funds. It is not necessary that a charitable organization originate from or be maintained by means of bequests, donations, and offerings from public moneys, nor need its representatives go on the streets with coin boxes or tambourines soliciting passers-by in order to supply its treasury. It may collect from those who are able to pay for services rendered to them and use the remaining surplus in its charitable work without loss of its status as a charitable corporation. Neither does the fact that petitioner purchased the hospital from a corporation organized for profit militate against its rights and privileges provided by law. Whether petitioner borrowed money for the purpose of constructing a new building and purchasing operating equipment, agreeing to repay the same in installments represented by bonds, or purchased an existing complete plant, paying for it in the same manner, the result is identical. *(Virginia Mason Hospital Ass'n v. Larson*, 9 Wash. (2d) 284, *supra; Commissioner of Internal Revenue v. Battle Creek, Inc.*, 126 Fed. (2d) 405, *supra.)* Neither a certain defined amount of its expenditures for charity nor the percentage thereof in relation

to its income or to its other expenses is the criterion. Not all of the patients need be treated free of charge. The number of free beds maintained by petitioner is only relative and is not important. There is no restrictive terminology in the statute from which it can be inferred that the legislature intended that a charity must be extensive in order to qualify under the law. To tax a nonprofit hospital is to place a direct tax on the sick and injured. The stipulated facts and the applicable law demonstrate that petitioner is organized exclusively for charitable purposes, that it is operated exclusively for such purposes, that no part of its net earnings inures to the benefit of any private shareholder or individual, and that by reason of the provisions of section 7 (g) of the act it is exempt from taxation under the statute and from the jurisdiction of respondents.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

The Los Angeles and San Francisco County Medical Societies are two component county units of large membership and interests.

At the close of the calendar year, the retiring officers presented reports in which current activities received comment.

Since most county societies are called upon to solve problems of somewhat similar qualitative nature, C. and W. M. presents here, for their suggestive value concerning county society work, the reports of Doctor John W. Cline, retiring president of the San Francisco County Medical Society, and Doctor Lewis A. Alesen, Secretary of the Los Angeles County Medical Association:

San Francisco County Medical Society

Annual Report of the President

The by-laws of the Society require that the president render, at the annual meeting, a report of the Society's activities during the preceding year. Having had the honor of being your president during the past year, I submit this report. There is much to be covered, but I shall make it as brief as possible and, to this end, shall divide it into several sections.

Activities Directly Associated With the War

Members in Service.—About three hundred members of the Society have requested leaves of absence for military duty. A sufficient number of additional members have joined the Service without the formality of requesting leave to bring the total of active members now in the service to about one-third of the entire Society.

Procurement and Assignment.—The State Procurement and Assignment Service under the able chairmanship of Harold Fletcher has met the difficult problem of enlistment in the Service and the maintenance of adequate civilian medical care in an orderly and efficient manner. It has had the complete coöperation of the Society's Committee on Procurement and Assignment, headed first by Doctor Fletcher himself and subsequently by Doctor Moore and Doctor Ebright. This committee has done splendid work and is deserving of commendation.

Selective Service.—Members of the Society have continued to render their services to the draft boards and the various phases of the selective service program generously and without compensation.

Special Service Fund.—The Special Service Fund with which you are all familiar now contains about $10,000. The cause is worthy and deserves far greater support than the membership has accorded it to date. It is to be hoped that the Society will respond with increasing interest and contributions.

Emergency Activities Arising From the War

Disaster Program.—Under the guidance of Henry Gibbons, III, acting first as chairman of the Medical Division of the Red Cross Disaster Program and later as the Medical Director of Civilian Defense, the Society has furnished the personnel of the hospital and station organizations for the care of the civilian population in the event of disaster. The plans have been developed and improved in constant consultation with officers of the Society. Recent improvements in the organization of this service have greatly increased its efficiency and make it more adaptable to any type of emergency.

Demands in Private Practice.—The reduction of numbers of physicians in private practice and the population increase in the community have placed additional burdens of practice upon those who have remained behind. The Society has been responsible for publicizing this fact and has urged that patients be as considerate as possible in making demands for professional services. We have asked that they give due consideration to the elements of necessity and time in making requests for service.

Health Service System.—After four years of negotiations, and at times, acrimonious conflict, with the Health Service System, a new era is apparent. There has been sufficient alteration in the personnel and attitude of the Health Service Board that coöperation in the solution of mutual problems now seems assured. The Board has made upward revisions in the rates for subscribers which should accomplish a 100 cent unit. It has given the Society assurance and impressed upon its own members that no satisfactory operation of the system can be expected until and unless the physicians rendering care to the municipal employees are paid in full. With this principle established, the major source of friction has been removed. In view of the friendly and coöperative spirit of the board and its medical director, A. S. Keenan, such minor difficulties as may arise should be easily adjusted without controversy. The committee headed by Stanley Mentzer has rendered a real service to the Society.

Well Baby Clinics.—For years, so-called Well Baby Clinics operated by city and private agencies, have proceeded to render partial and in some instances extensive medical care to the community without adequate supervision and without social service eligibility requirements or investigation. The Society has taken the position that it is desirous of furthering the care of the deserving but that extension of free care to the undeserving is an imposition upon the taxpayers, staffs of these clinics and the medical profession. The matter was laid before Mr. Thomas Brooks, Chief Administrative Officer of the city, and he has directed the inclusion of social service costs for one of these clinics in the next budget. If the results of this investigation establish what appears to be the actual situation, we can look forward to the time when these agencies will be brought under social service rules comparable to those of the San Francisco Hospital.

C.P.S.—The Society has continued to give excellent support to the California Physicians' Service, and the wisdom of this course is now clear. C.P.S. has grown and has expanded into new fields. It has taken over the medical care in the federal housing projects in the San Diego, Los Angeles, Marin and Vallejo areas and is soon to add others. C.P.S. has already changed many of its contracts and is in the process of changing most of the remainder from full to limited coverage. This change has been reflected in some increase in the unit value and material improvement will soon follow.

The short-sighted attitude of certain county societies toward C.P.S. is scarcely understandable. One society has already paid for it by having a well-financed, well-

organized, closed staff organization set up in its community. Such groups are bound to result in ultimate detriment to both the patient and the profession. Let us hope that the mistakes of the past will not be repeated.

As the war progresses, particularly after its conclusion, C.P.S. will prove of inestimable value and will stand as a monument to the vision and public spirit of the medical profession.

Hospital Conference Liaison Committee.—There has been increasing coöperation between the Hospital Conference and the County Society. Some time ago, the Conference asked that a liaison committee of three members from each body be established. This committee was created and a number of meetings have been held. One of the concrete results of this coöperative endeavor was prevention of the approval of a proposed surgical indemnification contract which was to have been issued by the Hospital Service of California in competition with C.P.S.

Standing and Special Committees.—The standing and special committees of the Society have done their work well. Time does not permit a discussion of all of these activities. The reports of these committees will be given tonight or published in the *Bulletin.*

Membership.—The active membership of the Society has been reduced. The number of new members during the past year is 104. When this is balanced against a loss of more than 300, it is apparent that a substantial reduction in total membership has taken place. The responsibility of those who remain has been consequently increased. In spite of the increased demands of practice, we must bear in mind that the County Medical Society is our organization and the representative of the medical profession in San Francisco. We must continue to support it in every way possible.

* * *

I wish to express my appreciation at this time for the hard work and complete coöperation of the officers, directors, committees and employees of the Society.

L. H. Garland, who is shortly to enter the navy, finishes his period of service as secretary of the Society, January 1st. While I hesitate to single out any individual member for special commendation, I cannot refrain from doing so in his case. He has established a standard for future secretaries in the zealous performance of his duties. His active and inquiring mind has been responsible for many of the projects of the concluding year and his capacity to translate thought into accomplishment has resulted in their completion.

Miss Lillian Moses has continued to render her customary excellent service to the Society as the executive of our offices. We are very fortunate to have her in this position. She has been ably assisted by Miss Nina Hansen.

For the past two years, we have had the services of Messrs. Lee and Losh in our public relations problems. It is probable that the Society's budget will permit continuance of their services. In many instances, their aid and counsel have been extremely valuable. We would regret the necessity of discontinuing their services, and are happy to know that we shall be able to call upon them at any time should occasion demand it.

The Woman's Auxiliary has given a splendid account of itself as usual. It has furnished the drivers for the Blood Bank delivery wagon and has solved a very difficult problem, not only for us but for the hospitals and the community at large. It gave splendid assistance in the ill-fated campaign for Proposition No. 3. Its work, in conjunction with that of Doctor Gaffney's committee, is largely responsible for the good plurality rolled up in San Francisco.

I am deeply appreciative of the honor you bestowed upon me by making me your president for 1942, and with this account of stewardship, I tender you my thanks.

December 8, 1942. JOHN W. CLINE.

Los Angeles County Medical Association

Annual Report of the Secretary

War, as we are well aware today, has a most far-reaching effect upon the Doctor of Medicine and upon the medical associations to which he belongs.

Never, perhaps, is there a greater need for medical organization than in time of war. Long before the attack on Pearl Harbor a year ago, your County Medical Association, aware of the probability of this country entering the world conflict at an early date, made plans for that eventuality.

So that your Association would be able to carry on its vital functions in behalf of public health and welfare and to serve the Doctor of Medicine and to protect the profession of Medicine in the great social and economic changes incident to war, first things were considered first.

Financial Status.—No organization can function effectively unless its financial status is sound. World War No. I taught medical societies throughout the country a severe lesson. Through the loss of great numbers of members many of these societies were so crippled financially that their activities, so necessary at such a time, became practically negligible.

As secretary-treasurer of the Los Angeles County Medical Association, I am most happy to report at this time that the financial status of your Association is excellent, due to financial planning more than three years ago for the possibility of war.

The finances of the Association have been carefully guarded. Income from dues, *Bulletin* advertising, and from income property has been conserved, and expenditures approved for only those activities deemed necessary and constructive.

No small part of the income of the Association is derived from the advertising pages of the *Bulletin.* You will all realize, I am sure, that during the past year all business has been severely affected by the war effort. However, in spite of this, and in spite of the fact that many of our nationally known publications have suffered a loss of advertising revenue, an increase in advertising revenue was achieved for the *Bulletin.*

However, the cost of publishing the *Bulletin* has shown an increase this past year due entirely to the increase in cost of paper, ink, and printers' charges. The *Bulletin,* however, at the end of the year will, as usual, show a most appreciable income to be used to further the activities of your Association.

Other income from annual dues is shown from *rentals of the property* at 1930 Wilshire Boulevard, in the sum of $12,500 a year. As in past years this item of income is used for the maintenance of the Library of the Association.

Constituting a large part of the income, of course, are *dues from members.* The Los Angeles County Medical Association collects from its members both its own and dues for the California Medical Association. This year the dues of the California Medical Association were $15.00. Dues for the Los Angeles County Medical Association also were $15, making a total of $30.00.

Membership.—At the beginning of the current year the dues-paying members of the Los Angeles County Medical Association numbered 2,850. Five hundred thirty-two of these members have been called to military service and thereby are exempt from the payment of dues. This number will increase. New members have been added, of course, during the year, but not in a number to com-

pensate for those going into service.

Dues.—This loss in dues paying members because of the war was given serious consideration by the House of Delegates of the California Medical Association at its meeting in Del Monte last May. That House of Delegates unanimously voted an increase in the dues of the California Medical Association of $5.00 for 1943. This was a necessary action to provide finances for the California Medical Association to carry on its vital activities for the year 1943.

The Board of Trustees of the Los Angeles County Medical Association at its November meeting, voted an increase in the Los Angeles County Medical Association dues of $2.50, making the dues of the Los Angeles County Medical Association $17.50 for the year 1943.

Economic and Social Problems.—All of us who read understand too well the problems that the profession of medicine is confronted with today. These problems are of great economic and social import. The profession of medicine has a grave responsibility . . . a responsibility that it accepted ages ago and one that it cannot relinquish. That responsibility is the health and welfare of the people the profession serves. So that the people may be served, it is essential that the profession of medicine itself be maintained. With many of our members serving with the armed forces and unable to lend their support in the work of maintaining for us and for them when they return, our professional integrity, it appears axiomatic that we who remain at home must carry a greater burden in this effort than we ever have carried in the past. A nominal increase in annual dues, after careful consideration, will appear but a small part of this burden.

Many of the activities of the Association carried on in past years have, since the outbreak of the war, been given more or less a place of secondary importance. The offices of the Association, beginning with the outbreak of the war, have been busily engaged in wartime activities, especially as relates to the creation, and staffing and later manning of the medical personnel, of the many casualty stations in this county.

The office of the Association has given a great deal of assistance to the Procurement and Assignment Committee. Details of these activities have appeared from time to time in the *Bulletin* of the Association, and should need no detailed comment here.

One of the important considerations to the members is the membership status of the Association. The loss of dues-paying members through death, leaves of absence, retirement, etc., totals 628, leaving as of November 1, 1942, a total of 2,222 dues-paying members. Each day members are leaving for military service. How many will be called before the end of 1943 we are unprepared to say.

The various standing and special committees of the Association have been exceedingly active. Our Council and our Board of Trustees have recognized the gravity of the situation that has existed during the past year and have met the various problems as they have arisen in a diligent effort to solve them.

Hospital Problems.—Especially active has been the Committee on Hospitals, Dispensaries and Clinics, under the chairmanship of Carl L. Mulfinger, M. D., which has met many times with representatives of the nursing profession and hospital officials in efforts to meet a most serious situation in Los Angeles County because of the great shortage of hospital beds and hospital personnel. Detailed reports of the accomplishments of this committee have appeared in the *Bulletin.*

Lay Publicity.—The Committee on Public Policy and Relations, under the chairmanship of Paul A. Quaintance, M. D., has, as in the past, done very commendable work in obtaining speakers on pertinent subjects for many lay groups.

While the activities of the Association have been directed largely to assist in the war effort, other important activities were not neglected, among them maintenance of the standards of the practice of medicine.

The facilities of the Association were used as usual by the various sections and specialty societies for their scientific meetings.

Members in Military Service.—The Los Angeles County Medical Association is in an excellent position to maintain for the duration its essential purpose in this community. We must not forget that the end of this year may find a total of 700 of our active members in military service. We must not forget that these members, while exempt from the payment of dues, are still our members and will expect their Association—and that means each member of the Association—to carry on as in the past, to protect the profession of medicine so that when they return, they will not find that we have been wanting in accepting our real responsibility.

L. A. Alesen.

Shall Organized Medicine Lead or Follow?

The following are excerpts from an address by George W. Cottis, M. D., Jamestown, N. Y., President, Medical Society of the State of New York, given before the First District Branch, Medical Society of the State of New York, St. Joseph's Hospital, Yonkers, New York, Wednesday, October 7, 1942:

I have not the answers to the questions which follow, neither, I venture to say, has anyone else. But the answers must be found and they must come from the only body of men having the necessary knowledge, the medical profession.

1. How can we bring a twelve-cylinder standard of medical services to a man who can barely afford a bicycle?

2. How shall we extend preventive measures to the whole population and so lessen the need for curative medicine?

3. How shall we provide institutional care for hopeless cancer patients?

4. How furnish enough convalescent homes to relieve our general hospitals of the burden of caring for patients with chronic ailments?

5. How provide proper care to our civilian population when the most virile one half of us are in the armed forces?

6. How care for defense workers and workers in general industry? How meet the demands of thousands of workers and their families today in an area where yesterday was only a scattered rural population?

7. How protect the public from its own folly in patronizing quacks?

8. How force venal politicians to pass such legislation as the Copeland bill to check false and dangerous labeling of drugs and foods?

9. How clear our own house of legalized quacks and fakers?

10. How force the speeding up of the production of doctors by casting out deadwood from curricula and rearranging courses?

11. How encourage and finance scientific research after large fortunes have been eliminated by government policy and private endowments are discontinued?

12. How are we to maintain our own freedom of thought and our own initiative in finding the answers to all of these questions in the face of a regimentation which already has replaced freedom of action in all industry?

As a nation we are beginning to appreciate the tremendous cost of the wishful thinking, wilful blindness and inexcusable ignorance of world affairs which resulted in our unpreparedness to meet what was plainly inevitable. As a profession we should profit by that experience and make sure that we know what is happening or is about to happen to us.

Society is an organism subject to all the laws of evolution. Medicine is an organ of vital importance in that

organism. There is of necessity a constant interrelationship between the two, and we cannot appraise our situation apart from that of society as a whole.

We must be aware that the World Revolution is not a revolution in the ordinary sense but a world-wide change as fundamental as that from feudalism to capitalism. Furthermore, we must accept this change as inevitable and very imminent. In fact it is already here. Its groundswell has been rolling toward us for many years, but it is only now when the wave has broken on our own shores that we are aware of its strength.

The "New Order" of the Nazis and Japs is only one manifestation of the change. The Russian experiment, the Swedish "Middle Way" and the American New Deal are all equally symptomatic of a new way of life.

It is with this background that we must consider what is ahead of us. We are paddling our canoe down a river with many bends and the current is running faster and faster. To drift blindly may lead to disaster. We cannot turn back, but we can stop paddling long enough to climb to some high point and see what is before us. If we can rise far enough we may get a bird's eye view. What would it show us?

Of course our nearest view would be that of the greatest nation on earth hamstrung during the critical prewar years by the myopia of its leaders, preparing terribly late to give its life blood to escape slavery. The wider view would be that of a world at war. But under the smoke and fire of battles we might see all the peoples of the world moving like a tidal wave in one direction. That direction is toward a new form of society in which independence is replaced by dependence and freedom traded for security. The leaders who promise these are the ones the people follow. The security they seek and demand is security against want, hardship and illness. That is the negative way of saying that they demand assurance of shelter, food, clothing, recreation and medical care, without much regard to their ability to earn them.

Now where do we, as a profession, fit into the picture? Most of our deliberations have been concerned with the question, "How are we to meet the issues that confront us?"

The primary question should be not "How?" but "What?" What are the demands of our changing social organization?

What portion of an individual's welfare is to be the concern of the State and what part is to be left to personal intiative?

What shall be the relation of organized medicine to the State and to the public?

What are the defects in our present system of medical care?

What changes or innovations are necessary to provide the highest standards of health for our people?

What is to be our own procedure in the circumstances? Are we to dig in our heels and pull against the trend or are we to set the objectives and assert and prove our right to leadership?—*"Medical News"* bulletin of the Medical Society of the State of New York, October 7, 1942.

Attendance at Meetings of District Medical Societies: Some New York Statistics

The Medical Society of the State of New York recently gave some statistics concerning attendance at district medical meetings, with a break-down of the age-groups of physicians who registered. The figures are naturally of interest to members of other state medical associations:

District Branch Attendance

An index of the impact of the war upon the Medical Society of the State of New York may be found in the attendance records of the District Branch meetings for this as compared with last year:

In 1941, the total attendance was 960; this year, 594.

In 1941, the average age of those who came was 47.39 years; this year, 51.98 years.

In 1941, the prominent decade was 35-44; in 1942, 45-54.

In 1941, the number under 45 years was 460; in 1942, 145.

In 1941, the number who were aged 45 was 25; in 1942, 25.

Repeaters *in the 7th decade:* 1941, 0; 1942, 9.

A further breakdown of age groups by periods of five years shows:

45-54=183, or 30.81 per cent in 1942; 242, or 25.21 per cent in 1941.

55-64=134, or 22.56 per cent in 1942; 155, or 16.15 per cent in 1941.

65-74=93, or 15.66 per cent in 1942; 94, or 9.79 per cent in 1941.

75-84=15, or 2.53 per cent in 1942; 15, or 1.56 per cent in 1941.

85-94=1, or 0.17 per cent in 1942.

It may be noted that the interest and alertness of the physicians of 65 years and older are well shown by this table. These men allow no grass to grow under their feet; they were on deck both this year and last to learn what was new and to signify their willingness, even eagerness, to bear their share of the burden and heat of the day—and the night, too, if need be.

No less interesting is the contrast in the lower age groups in the two years. In the group

25-34 years, 136 attended in 1941; 36 in 1942:—7.69 per cent.

35-44 years, 322 attended in 1941; 132 in 1942; —11.32 per cent.

45-54 years, 242 attended in 1941; 183 in 1942: —5.60 per cent.

Bald and gray heads seemingly will carry on to the limit of their ability, always eager to learn that they may better serve.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Medical Students' Deferment Urged

Brig. Gen. Charles C. Hillman, surgeon general of the U. S. Army, on November 21st, stated that the supply of future physicians required for both the military and civilian effort "must not be curtailed at the source."

Explaining that the lowering of the draft age to 18 created new problems to medical and premedical students, Gen. Hillman expressed hope that the War Department would work out comprehensive plans to assure a continuous supply of new physicians for essential industries and civilian communities.

Gen. Hillman, speaking at an American Medical Association conference yesterday, said that unless provision was made to assure a minimum of two years' premedical education for those planning to enter medical schools, "only women and the physically unfit would be able to enter medical schools."

To Train M.D.'s

Chicago.—(UP.)—The Council on Medical Education and Hospitals of the American Medical Association has adopted resolutions to shorten the period required for a M. D. degree from eight years after graduation from high school to five years. This shortened curriculum, as reported by the A.M.A. *Journal*, will be in force for the duration of the war.—Oakland *Tribune*, December 20.

Army Medical Plan Enlists U. C., Stanford

The medical and dental schools of the University of California and Stanford are scheduled to take part in a special training program under which several thousand Army medical and dental officers will receive specialized training, Secretary of War Stimson announced in Washington, D. C., on December 31st.

From 200 to 400 officers will be selected for each class, which will begin today.

"Distribution of professional medical men trained for

medical and surgical specialties," the Secretary said, "has proved inadequate to meet the demands of war. But a number of Army Medical Corps officers can, with a short intensive course, become qualified to help eliminate the deficit in that specialty."

Chancellor Ray Lyman Wilbur, of Stanford, said yesterday that the Stanford medical school is already training a group of some 20 Army doctors in thoracic surgery.

Who'll Fight—and Who'll Study—U. S. to Decide

College to Go on Wartime Footing as Manpower Crisis Becomes Acute

Washington dispatches put the query, "Who is going to college" as a question that is rapidly becoming one of the big problems of wartime.

With the draft lowered to include 18 year olds, the question became, so far as young men are concerned, largely one for the Government rather than the individual to determine.

Part of the answer already has been given in the Army and Navy announcements of their training programs. The rest is yet to come and may stir up a lively debate in the new Congress.

Paul V. McNutt, the war manpower commissioner, gave a hint of what high officials have in mind when he announced this week that more than 150,000 college men would get temporary draft deferment to continue medical, engineering and other specialized scientific training.

Program Incomplete

The deferment will last until the end of the school year and meantime, McNutt said, plans will be worked out for the education of a number of civilians by Government financing. . . .

Bay Colleges Waiting on Army and Navy

Bay Area colleges today awaited identification by the War and Navy Departments of the 200 to 300 institutions which it was announced in Washington, will be used to give specialized training to young men in the armed services. . . .

In Washington, Secretary of War Stimson said the new joint Army-Navy program would go far toward temporarily destroying liberal education in America but would have no permanently bad effect. . . .

School at Del Monte

A pre-flight school announced recently for Del Monte, accommodating about 1,500 students using facilities of the Hotel Del Monte, will be opened about February 4, the Navy said today. Its commanding officer will be Captain George Washington Steele, USN (Ret.), who has headed the St. Mary's Pre-Flight School since it opened. . . .

The Army and Navy will contract with the selected institutions to furnish instruction in prescribed courses and to furnish housing and feeding facilities. Men sent to college by the services will be on active duty and wear uniforms, receive service pay and be subject to discipline. . . .

Special Provisions

Special provisions are made for enlisted reserves. Medical and premedical students, four-year ROTC students and junior students in the enlisted reserve taking engineering courses, will be continued on an inactive status until the end of the next academic semester which begins after today. All other enlisted reserve students will be called to active duty at the end of the current semester. On completion of basic military training, they will be eligible for selection for academic training under the program.—San Francisco *News*, December 17.

U. S. Plans to Subsidize Medical Students

Washington, Dec. 23.—(UP.)—The War Manpower Commission announced in December that it was working on plans to subsidize men and women in the study of medicine and other sciences to fill civilian wartime needs and prepare for the postwar period.

The Army and Navy already have publicized plans for training members of the armed forces to meet their needs.

The number of persons to be given higher education through the WMC program depends on how much money is appropriated for that purpose by Congress. WMC Chairman, Paul V. McNutt, said the request would go to Congress next month.

How young men and women will be chosen for WMC-subsidized education has not been decided, officials said, but the emphasis will be on the education of doctors, chemists and engineers. . . .

Enrollment of Universities Drops 13.9 Per Cent

Cincinnati, Dec. 21.—(AP.)—Dr. Raymond Walters, president of the University of Cincinnati, today reported sharp decline in attendance in 667 American approved colleges and universities during 1942.

"The university law schools and graduate schools of arts and sciences were hit the hardest."

Declines of approximately 9.5 to 10 per cent in full-time students, 13 9-10 per cent in grand totals, including part-time and summer session attendance were noted in Walter's twenty-fourth annual enrollment survey for School and Society and Educational Weekly.

The 667 institutions had 746,922 full-time students and a grand total of 1,075,849 as of November 1, Walters reported.

Freshman enrollments were down 1.7 per cent, but freshman enrollments during the fall in technological institutions were up 9.2 per cent.

A drop of 22.5 per cent in attendance at 78 teacher colleges was reported. Law schools in 83 universities declined 51.3 per cent and graduate schools 29.9 per cent.

Considering full-time enrollments, the University of California again headed the list with 18,364 students.—San Francisco *Chronicle*, December 22.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

San Bernardino County Hospital

Patients Able to Pay for Hospitalization Must Do So

Persons who are able to pay for services and treatment received at the San Bernardino County Hospital must do so or face the possibility of court action with the county suing to recover.

This is the effect, observers pointed out, of the revision of the hospital's collection system following recommendations from the grand jury and the board of supervisors.

Although the county hospital ordinarily accepts only charitable cases, persons who are able to pay for hospital care are accepted in the isolation ward if they are suffering from contagious diseases, or are injured in an accident and require emergency treatment. Other hospitals are not equipped to handle contagious diseases.

County Auditor Vincent L. Roth, made a special check of the records of the isolation ward and emergency cases, and his report to the board showed that 972 cases

were handled in the hospital in the two classifications between last July 1 and Sept. 28.

Of these, Mr. Roth said, 485 were charity cases and 478 cases were those of patients able to pay for their care. In this latter group, 83 persons have paid their accounts in full. Mr. Roth said letters requesting payment were issued to the remaining 404 persons and to date, 59 said they would pay their bills. Of the 59, said the auditor, 17 have made partial or full payment. The auditor's letters were not acknowledged by 231 persons while the correct addresses of 83 have not been found.

There were 31 persons who have bills for ambulance service, but these are not proper hospital charges but are payable to mortuaries and persons operating ambulance service, said Mr. Roth.

Under the new system installed in the hospital, as soon as possible after the entrance of a patient in the hospital in either the emergency division or isolation ward, a social service worker shall establish the hospital treatment.

Rubbing Alcohol Priorities

Copy of a Resolution approved by the Executive Committee of the California Medical Association, at its meeting of December 13, 1942, follows:

WHEREAS, The use of rubbing alcohol for local use in cleansing and protective purposes on the skin of patients is an accepted part of hospital procedures; and

WHEREAS, It would appear that many of the smaller hospitals located in California (according to a recent ruling of the governmental authorities through directive W.P.B.—M-30, with respect to the use of ethyl alcohol and related compounds), will be deprived of the right to secure an adequate amount of rubbing alcohol, in like manner as that right is given to certain larger hospitals and to members of the medical, dental and veterinary professions and certain governmental agencies; and

WHEREAS, Under existing war conditions, because of which the number of nursing and other aide personnel who look after patients is considerably diminished, so that it is no longer possible in many institutions to give the same amount of soap and water bathing and similar care to patients (a considerable number of whom may be citizens brought in from essential industry plants); and

WHEREAS, The order as it now exists would seemingly work, not for the fullest protection of the public health or of workers in essential industries, but rather to the detriment of such, who may come under care in a goodly number of smaller hospitals in California; now, therefore, be it

Resolved, By the California Medical Association, through its Executive Committee, that the request of the Association of California Hospitals for a modification of the orders having to do with this problem be endorsed; and that the California Medical Association, representing more than seven thousand licensed physicians, many of whom are in military service hopes that the necessary directives will be issued by which the best interests of the public health, insofar as hospital care is concerned, shall be conserved, through modification of the order referred to above.

Charitable Hospital Not Employer, Ruling

Los Angeles, Dec. 17.—(AP.)—A charitable hospital is not an employer within the meaning of the California unemployment insurance act, and therefore need not contribute to the State insurance fund on behalf of its employees.

Superior Judge Emmett H. Wilson so ruled in a suit brought by Seaside Hospital, Long Beach, against the State insurance fund. The hospital contended it accepts all patients, regardless of ability to pay, and that all members of the County Medical Association are eligible for membership on the hospital staff.—Oakland *Tribune*, December 17.

Free Clinic Hospital to Help Tubercular Patients Provided for in Charles Hastings Will

Research Center to Be Supported by $3,000,000 to $4,000,000 Endowment Fund; Institution to Rise Near Pasadena and Be Known as 'The Charles Cook Hastings Home'

Creation of a clinic hospital, a free research center for the treatment of tubercular patients and supported by a $3,000,000 to $4,000,000 endowment fund, has been made possible by the late Charles H. Hastings, owner of the famous Hastings Ranch, northeast of Pasadena, as revealed by his will, filed here yesterday for Commander Ernest Crawford May, by Cruickshank, Brooke & Dunlap, his attorneys. The will was submitted to probate about a fortnight ago in the Surrogate's Court of New York County, New York, where Mr. Hastings died domiciled, after a delay of approximately 10 months during which time extensive negotiations were conducted and successfully concluded with the heirs of Mr. Hastings, who were four cousins, all of advanced age and who had through their legal representatives filed a contest to the will. . . .

The clinic hospital, to be known as "The Charles Cook Hastings Home," in memory of his California-pioneer father who died of tuberculosis in 1890, ultimately will rise near Pasadena. . . .

While the will explicitly defines the objectives of the clinic hospital, all details such as size, location, operation and possible additional fields of medical research are left in the hands of the Hastings Foundation, incorporation papers for which will be filed promptly in Sacramento as directed in the will. The board of directors of this foundation is given the widest latitude in attaining Mr. Hasting's objectives.

Free Treatment

In his will he wrote:

"I have long contemplated organizing a nonsectarian charitable corporation under the name of 'The Hastings Foundation' for the study, prevention, treatment and cure of tuberculosis. . . . Such corporation shall have power to erect, equip and maintain a sanitarium . . . and it shall be conducted and maintained on a strictly charitable basis and no charge shall be made to patients therein, or for any treatment or other aid rendered thereby. Such corporation shall also be authorized to undertake the study, prevention, treatment and cure of other diseases, so that if at some future time said board determines that it is advisable to use its facilities, in whole or in part, in order to combat some other disease or diseases, it would have power to do so." . . .

In the incorporation papers, Commander May, Dr. Leroy B. Sherry and Lloyd W. Brooke appear as the foundation's original board of directors, additional members to be elected by the board as needs indicate. . . . —Pasadena *Post*, January 1.

Army, Navy, industry, public health—all must fight together and against tuberculosis.—Charles E. Lyght, M. D., *Amer. Rev. of Tuber.*, Sept., 1942.

Cow's milk contains three to four times as much calcium as human milk.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (22)

San Francisco County (16)

Grace Gunn Binger, *San Francisco*
Louis Sanders Constine, Jr., *San Francisco*
Morris E. Dailey, *San Francisco*
James R. Drake, *San Francisco*
Karl B. Eichorn, *San Francisco*
Ruth Fleming, *San Francisco*
Don G. Gardner, *San Francisco*
John Jay Hawthorne, *San Francisco*
William H. Ice, *San Francisco*
William Cortlett Keig, *San Francisco*
Hans Rathmann, *San Francisco*
Mary Mable Schmeckebier, *San Francisco*
Frederic Porter Shidler, *San Francisco*
Marion Alan Swanson, *San Francisco*
Nicholas Tesauro, *San Francisco*
William B. Wallace, *San Francisco*

San Luis Obispo County (1)

Harrison Eilers, *San Luis Obispo*

Santa Clara County (3)

Ann Franklin Barnett, *Palo Alto*
Robert Allen Lochr, *San Jose*
R. P. Quirmbach, *Agnew*

Solano County (1)

John Neal Clark, *Fairfield*

Transfers (1)

Lester S. McLean, from *San Bernardino County* to *Solano County*

In Memoriam

Crum, Howard Charles. Died at Santa Cruz, July 29, 1942, age 58. Graduate of Chicago College of Medicine and Surgery, Illinois, 1910. Licensed in California in 1915. Doctor Crum was a member of the Santa Cruz County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Graham, Rossner Enders. Died at Oakland, October 6, 1942, age 55. Graduate of Tulane University of Louisiana School of Medicine, New Orleans, 1914. Licensed in California in 1922. Doctor Graham was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Hall, Channing. Died at Alameda, December 14, 1942, age 57. Graduate of Cooper Medical College, San Francisco, 1911. Licensed in California in 1911. Doctor Hall was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Harris, Wayne Adelbert. Died at Santa Ana, November 25, 1942, age 62. Graduate of the University of Illinois College of Medicine, Chicago, 1904. Licensed in California in 1927. Doctor Harris was a member of the Orange County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Lane, John Alexander. Died at Eureka, November 13, 1942, age 69. Graduate of Cooper Medical College, San Francisco, 1898. Licensed in California in 1899. Doctor Lane was a member of the Humboldt County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Porter, Ernest Boring. Died at Altadena, November 16, 1942, age 47. Graduate of Northwestern University Medical School, Chicago, 1925. Licensed in California in 1925. Doctor Porter was a retired member of the San Diego County Medical Society, and the California Medical Association.

✣

Sawyer, Edmund Houghton. Died at San Francisco, November 17, 1942, age 61. Graduate of Harvard University Medical School, Boston, 1908. Licensed in California in 1909. Doctor Sawyer was a member of the Mendocino-Lake County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Spalding, Alfred Baker. Died at San Francisco, November 25, 1942, age 68. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1900. Licensed in California in 1902. Doctor Spalding was a retired member of the San Francisco County Medical Society, and the California Medical Association.

✣

OBITUARY

Frank E. Detling

1876—1942

Frank E. Detling was born May 23, 1875, at Plymouth, Wisconsin, the son of Val and Anna Marie Detling. He was educated in the public schools of Plymouth, and attended the Northwestern University Medical School, from which he was graduated in 1901. He served his internship at St. Mary's Hospital in Duluth, Minnesota, and his record at this hospital was so excellent that the Attending Staff requested him to open an office in Duluth, which he did and there practiced for several years.

Early in his career he decided to specialize in diseases of the eye, ear, nose and throat, and devoted all of his spare time to that study. In 1908, for several months, he attended the clinics of New York. He was Resident of the Wills Eye Hospital of Philadelphia from 1908 to 1909. About this time Dr. Robert W. Miller of Los Angeles, wrote to the Wills Eye Hospital for an Associate in his practice. Dr. Detling was highly recommended and after finishing his residency and visiting other Eastern clinics, he came to Los Angeles in 1910, to become associated with Dr. Robert W. Miller. One year later he was married to Betty G. Walsh at Superior, Wisconsin. Following his association with Doctor Miller for three years, he opened his own office.

Soon after his arrival in Los Angeles, Doctor Detling was appointed Instructor in Otolaryngology in the University of California Medical School and Otolaryngologist to the Graves Dispensary. He was later appointed to the Staff of the Children's Hospital, where he remained as Attending and Consulting Otolaryngologist until his death. For some twenty-five years he was one of the Senior Otolaryngologists to the Los Angeles County General Hospital. He developed one of the out-

† For roster of officers of component county medical societies, see page 4 in front advertising section.

standing departments of the hospital and devoted a great deal of time and energy to this institution.

Later, when the School of Medicine of the University of Southern California was organized, Dr. Detling was one of the first to be enrolled on the Staff as Associate Clinical Professor of Otolaryngology. He had much to do with the organization of the clinical teaching of the school. He devoted a great deal of time to duties at the Children's and County Hospitals and the School of Medicine, and often said that his happiest moments in practice were those spent in attending to these duties. He devoted his life to his profession and in doing so was very happy.

Doctor Detling was a Past-President of the local Eye and Ear Society, and Chairman of the Eye and Ear Section of the State Society. He always took an active interest in medical society work. His discussions were to the point. He was a most lovable character and no one in the profession commanded more respect for his knowledge and sincerity.

He was devoted to his family. He leaves a wife, Betty, a son, Val, and two brothers in Wisconsin.

J. M. Brown,
S. Jesberg.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

County Auxiliary News Items

The Woman's Auxiliary to the Los Angeles County Medical Association held its November meeting, at 12:30, on Tuesday, November 24, at the Los Angeles Athletic Club. There were eighty-four members and guests present.

Miss Eleanor King, author, columnist, and radio artist, gave an interesting and enlightening talk on "Charm." She stressed the fact that health and good posture are important factors in being a person of charm.

Guests of honor were Dr. Vincent Askey, Chairman of the Board of Trustees of the Board of Education; Dr. C. Morley Sellery, Director of Health Service, Los Angeles City Schools, and officers of the first and tenth districts of the Parent-Teachers Association. Hostesses for the day included Mrs. Raphael Dunlevy, Chairman; Mrs. Philip Stephens, and Mrs. Paul Dougherty.

Mrs. Donald Charnock, War Activities Chairman, announced that Tuesday, December 15, would be the Auxiliary's Day at the Red Cross Blood Bank. She and her committee are working diligently to make this a success.

Members of the Riverside County Medical Auxiliary met at the home of Mrs. H. W. Naeckel for their annual benefit bridge party. Funds from this benefit are to be used for subscriptions to *Hygeia*, to be placed in schools and other public places. Mrs. Ralph Smith was Chairman. During the tea hour, Mrs. George Rue entertained with piano selections.

† Prior to the tenth of each month, reports of county chairmen on publicity should he sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

The December meeting of the Woman's Auxiliary to the Marin County Medical Society was held at the Blue Rock Hotel, in Larkspur, on Thursday evening, December 3. The president, Mrs. Rodney Hartman, presided.

A short business meeting followed. It was decided to have, in the near future, individual bridge parties put on by members, to raise money for the treasury.

An extremely enjoyable talk was made by the guest speaker of the evening, Mrs. Roy Nisja, who is a well-known Marin County nutritionist and instructor at the Marin Junior College. Her talk on nutrition was instructive, and made more interesting by colored charts which brought out the rapidly-changing food picture.

Dr. Clifford Kuh, Chief of the State Bureau of Public Health, addressed the Woman's Auxiliary to the San Francisco County Medical Society at their regular meeting on the 17th of November. Dr. Kuh's subject, interesting and timely, was "Health Problems Raised by the Employment of Women in War Industry."

Tea was served to about fifty members and guests. Mrs. Norman Morgan, Hospitality Chairman, was assisted by Mrs. Roger McKenzie and Mrs. J. C. Long.

Members of the Auxiliary were hostesses at the Hospitality House on December 4, 1942, for the second consecutive year. Mrs. Roger McKenzie, Chairman, and Mrs. Norman Morgan, Co-Chairman, assisted by a splendid committee, planned a very entertaining day for the boys in the armed forces. Mrs. William Reilly, Mrs. Edmund Morrissey and Mrs. Raleigh Burlingame were hostesses.

The Woman's Auxiliary to the Fresno County Medical Society enjoyed the company of Mrs. Lindemulder at the November luncheon, held in the University-Sequoia Club. Mrs. R. W. Dahlgren, President of the Fresno group, presided and introduced Mrs. Lindemulder to the members and guests, who included several of the wives of medical officers stationed at Hammer Field. It was an interesting meeting, for, after a brief talk, Mrs. Lindemulder invited an informal discussion on matters pertaining to Auxiliary work.

Miss Maude Schaeffer, who recently returned from Honolulu, was guest speaker at the December meeting. She talked on the conditions in Honolulu before and after December 7.

It was decided to furnish a recreation room for the use of the bachelor doctors on duty at Hammer Field. Mrs. J. R. Walker will take charge of this project.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (October)		35,000
Rural Health Program		3,500
War Housing Projects (January 1st) (Approximate)		31,800
Vallejo	10,000	
Marin	5,000	
Los Angeles	6,800	
San Diego	10,000	

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

The year 1942, as was expected, was a difficult one. The rapid turnover in employment caused by the change-over to a war economy resulted in a serious loss of membership. New business to offset this loss was difficult to obtain for the same reason. Despite these difficulties, C.P.S. was able to maintain an average membership of 38,000 to 40,000 throughout the year.

C.P.S. has also undertaken an important change in its basic contract—from the old "Full Coverage" to the "Two Visit Deductible" and "Surgical" plans. These new contracts are designed to bring the unit value up to par, and the process of conversion is well under way.

The true value of C.P.S. has become apparent in the last year. When Federal Agencies were confronted with the problem of securing medical care for transient war workers, it is interesting to note that these Federal Agencies singled out C.P.S. as the only medical care organization in the United States with which it could work out these problems, and the only doctor-owned agency that was ready and able to meet the need.

Medical Service Plans Discussed at Annual Session of State Medical Association Secretaries and Editors at A.M.A. Headquarters

The Journal of the American Medical Association printed the addresses and discussions on medical service plans, medical licensure and kindred topics in two recent issues (December 12, pp. 1244-1235, and December 19, pp. 1315-1324). Numerous references were made to California plans. Comments by Doctor George H. Kress, Secretary of California Medical Association, appeared on pages 1232, 1233 and 1322. To the credit of the California Medical Association, it may be said that no State medical association can show a broader approach to the issues involved in medical service plans: Agricultural Workers Health Care; Federal Housing; Federal Social Security for Rural Farm Families; and Statewide coverage offered by California Physicians' Service. C.M.A. members will find many items of interest in the addresses and discussions presented at the recent Conference of Secretaries and Editors.

Unusual Medical Plan Is Used By Housing Tenants

Chicago, Dec. 7.—(CCNS.)—Families at the Marin City, Calif., war housing development, are financing their medical care on a prepay plan through a tenants' mutual health association, according to the National Association of Housing Officials.

Complete medical care, surgery and hospitalization are furnished under the plan by agreement with the California Physicians' Service, a nonprofit organization which operates a Statewide prepayment medical service. Fees are $5 a month for a family with children, $4 for a two-person family, and $2.50 for a single person.

A medical center is set up in the housing project, supplied with equipment and staffed by nurses and one resident physician for each 1,500 persons.—Los Angeles *Greater Los Angeles*, December 11.

Workers Meet Health Costs With Rentals

Persons in Housing Projects Pay Insurance in Advance, Doctors' Group Reveals

San Francisco, Dec. 10.—(AP.)—Health insurance paid in advance as part of the rent is already in effect for 8,000 California war workers in federal war housing projects, and soon will spread to 100,000 more, officials of the California Physicians' Service disclosed today.

Dr. A. E. Larsen, medical director of the doctors' organization, said the program took root among San Diego airplane workers last May and now includes Marin County with its new Bechtel Shipyard and Hamilton Field, Los Angeles, with its airplane plants and shipyards and the vast Vallejo shipbuilding area.

They All Agree

In each case, Dr. Larsen said, local physicians' groups, the C.P.S., the federal public housing authority and the local housing authority came to complete agreement on the matter.

The cost of protection, available only to those living in war housing projects, is $2.50 a month for a single worker, $4 for a man and his wife and $5 for a man, wife and family.

Patients with minor illnesses are treated in the clinic provided at each housing project. If their illness is serious, they are advised to consult a private doctor of their own choice, the bills being paid out of the accumulated pool.

Dr. Larsen said many doctors have been brought from towns left nearly depleted by the exodus to war plants, and alien physicians, unable to obtain commissions in the army or navy, have been given jobs caring for war workers.

"This is not State medicine," he said, "but it merely shows that the medical profession has found a way of working with the government."—San Bernardino *Sun*, December 12.

Physicians Get Prepaid System Extended Here

San Diego, Calif.—A new medical plan for war workers is being launched in West Coast housing projects by the California Physicians' Service, in agreement with the Federal Housing Authority. The plan is already in operation at the Linda Vista project, near here.

The plan provides full medical care, including hospitalization, at monthly rates of $2.50 for a single man, $4.50 for a couple and $5 for a family with children.

A medical center staffed by resident physicians and nurses is built at each project covered by the plan.

The C.P.S., sponsored by the California State Medical Association, was organized four years ago as a Statewide prepayment medical service. Despite suspicion that the organization was started to head off a strong movement for State-operated health insurance, the present plan has been approved by union representatives and physicians who favor group medicine.—Richmond *Labor Journal*, December 11.

Paying the Doctor In Advance

Doctors have many bills on their books that will never be paid, but out in California the story is a lot different. There several thousand families in California's war-plant industrial communities pay their doctor in advance just the way they pay their rent. And, in a few weeks, 35,000 of California's farm families will be using a similar pay-in-advance plan for their physicians.

Besides insuring that the doctor gets what is coming to him the plan has definite advantages to the patient in that medical care costs a lot less in this way.

In cities where the idea is in force, the money paid for medical care goes to the Housing Authority which turns it over to the California Physicians' Service which assigns doctors and nurses to the sick and maintains clinics.

The plan for farm folks, as announced by the Farm Security Administration and the California Physicians' Service, allows about 130,000 persons, members of the 35,000 families, to join if the family's net yearly income is $2,000 or less. Last year, in three experimental counties, this care cost between $10 and $20 per person a year.—Los Angeles *Examiner*, December 6.

Applications Are Being Received in Health Association

Applications are now being received for membership in the Farmers' Health Association which is being formed throughout Merced County to help the farmers meet the high cost of illness and accidents.

Any farmer or farm laborer is eligible to join if he receives more than one-half his living from the farm and had not more than $2,000 net income in 1941. The cost is $20.50 per person with $60.50 the most that even the largest family pays for a year. All the necessary medical, hospital and surgical care for children under nineteen, maternity care, and treatment of acute illnesses and accidents for adults are furnished for this fee which is paid in advance. Hospitalization is allowed up to 21 days for each separate illness.

Of the 5,000 doctors who belong to the California Physicians' Service, any one may be chosen for the family doctor. All licensed doctors of medicine are eligible for membership in the California Physicians' Service.

For further information, call Merced 1405. Application blanks may be obtained from Mrs. Catherine C. Simson, Secretary of the Organizing Committee, 105 Business and Professional Building, Merced, California.

It is necessary that all applications and money orders or checks made payable to California Physicians' Service be in by December 10, so service may begin early in January.—Merced *Sun-Star*, December 10.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1942.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In January KFAC will present these broadcasts on the following Saturdays: January 2, 9, 16, 23, and 30.

The Saturday broadcasts of KECA are given at 10:30 a. m., under the title "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.



John C. King, M. D., President of the California Medical Association in 1910, who will attain his 90th Birthday on February 9, 1943.

It is a pleasure to bring to the readers of CALIFORNIA AND WESTERN MEDICINE word of one of our oldest State Association Presidents, Doctor John C. King of Pasadena, who, on February 9, 1943, will celebrate his 90th birthday. After a long life of great usefulness, Doctor King is still alert, mentally and physically; and although he has withdrawn from active participation in professional interests, he is down-to-date on the proceedings of medical organizations, and keeps well informed regarding new discoveries and advances in medicine and surgery.

Doctor King was born in Pittsburgh, Pennsylvania, February 9, 1853. He was educated at Newell Institute, and received his M. D. degree at the University of Nashville in 1874. He served as an intern in Pittsburgh Hospital where he was on the Dispensary staff. Upon coming to California, he at once began an active interest in medical and civic affairs. He was president of a high school board for 20 years; he helped to organize the San Bernardino County Medical Society, and became its president; he was also president of the Riverside County Medical Society, and later president of the Southern California Medical Society, and in 1910 he was elected

president of the California Medical Association.* In 1923 he retired from the practice of medicine in Banning, where he specialized in tuberculosis, and removed to Pasadena.

In addition to his active professional life, Doctor King has been an earnest student of the Bible, and for sixty-five years has given continuous service to both church and Sunday Schools, as either superintendent or teacher. On December 27th, he brought to a close this phase of his activity, and on that afternoon hundreds of his friends gathered at his home in Pasadena to do him honor.

Since retiring from active practice 20 years ago, Doctor King has engaged in the delightful hobby of cultivating fine flowers, devoting himself in his large garden, especially to choice roses and magnificent dahlias, which he has generously sent to hospitals and churches. He has done, and still does, the major part of the gardening, himself—eating his simple breakfast at seven o'clock, working through the early morning, and then resting and reading through the remainder of the day.

Because of his successful practice, and his noble life, Doctor King is held in highest esteem by the profession, and in truest affection by his numberless friends.

The members of the California Medical Association extend to him, all good wishes.

Pharmacological Items of Potential Interest to Clinicians:**

1. *Lots More New Books:* Galveston Orchids (Oleanders), to L. Untermeyer for his fine anthology of British and North-American poetry, including M. Moore's but not Wm. Ellery Leonard's. Ralph L. Woods' "Treasury of the Familiar" (MacMillan, 1942), is also well designed for the average North-American. Tops in autobiography is L. P. Jacks' philosophical "Confession of an Octogenarian" (MacMillan, 1942). C. M. Wilson's "Ambassadors in White" (The Story of American Tropical Medicine, Holt, 1942), is the usual superficial journalist's account derived from the obvious sources. Edgar Erskine Hume's "Ornithologists of the U. S. Army Medical Corps" (Hopkins, Baltimore, 1942), is a charming 580-page tome covering 36 biographical sketches in the best Humian style and you'll be surprised that Sternberg, Munson, and Leonard Wood were ornithologists, as well as the great Casey Wood. W. J. S. Krieg's "Functional Neuroanatomy" (Blakiston, Phila., 1942), is an artistic triumph, initials and all. A helpful volume is G. W. Corner's "The Hormones and Human Reproduction" (Princeton, 1942). It's pleasing to see A. J. Quick's scholarly and practical "Hemorrhagic Diseases and Physiology of Hemostasis" (C. C. Thomas, Springfield, 1942). V. H. Moon discusses *Shock: Its Dynamics, Occurrence and Management* (Lea and Febiger, Phila., 1942). Then there's *The Time of My Life*, by H. C. DeVighne, Alaska's frontier doc (Lippincott, 1942). And P. A. Sorokin's *The Crisis of Our Age* (Dutton, N. Y., 1942). As well as R. West's *Conscience and Society* (Methuen, Lond., 1942). In addition to H. Trevelyan's *Gothe and the Greeks* (Cambridge, 1942), and M. Rostovtzeff's 2 vol. *Social and Economic History of the Hellenistic World* (Oxford, 1942)—in contrast to J. Needham and J. S. Davies' *Science in Soviet Russia* (Watts, Lond., 1942), for forty cents.

2. *On Burns:* C. K. Drinker & Co. (Surg., 12:685, 1942), begin series of studies on lymph flow from burned tissues. Ralph Pendleton's Open-Air Paraffin Wax Spray Treatment is succinctly described in a 4-page folder listing 14 advantages, with details and illustrations. Write for copy to U. S. Naval Hosp., Mare Island, California.

3. *Renin:* October issue *Amer. J. Physiol.* gives practical symposium: G. E. Wakerlin & Co. find little prophylactic value in experimental renal hypertension; E. Ogden & Co. find renin does not pass the placenta and that fetus is much less responsive than mother; while M. Friedman & Co. note that daily injections aren't much use in hypertensive dogs (137:515; 473 and 570, 1942).

4. *Transfusion Data:* A. Bagdasarov (Central Blood Inst., Moscow), describes Russian transfusion methods (*Brit. Med. J.*, 2:445, Oct. 17, 1942). J. Beattie (*Lancet*, 2:445, Oct. 17, 1942 ref. O.K.!), in describing fate of transfused plasma, notes rapid loss of fluid and protein from circulation after transfusion. H. A. Davis and G. R. Meneely (*Science*, 96:468, Nov. 20, 1942), in discussing probability of obtaining potentially dangerous pools of human serum or plasma, suggest using large number of components and estimating iso-agglutinin titer to reduce risk.

5. *Infections:* T. J. Mackie (*Edin. Med. J.*, 49:607, 1942), neatly reviews the problem of those that may be air-borne. O. H. Robertson & Co. (*J. Exper. Med.*, 75:593, 1942), show propylene glycol spray (1 gm./2 000 liters of air), is effective air disinfectant, and of course, nontoxic.

6. *Wind-Ups:* H. O. Calvery's swell review (*Amer. J. Pharm.*, 114:324, 1942), of food, drug, and cosmetic coal-tar colors gives name and formulae of certified ones Have you spotted the resurgence of the *Chemical Warfare Bulletin*, now in its 28th vol.? A. J. Henry and D. N. Grindley (Khartoum), in describing method of estimating stilbamidine in biological fluids (*Ann. Trop. Med. Parasit.*, 36:102, 1942), note its absorption on blood corpuscles. C. C. Ungley and W. Blackwood (*Lancet*, 2:447, Oct. 17, 1942), discuss immersion foot peripheral vasoneuropathy after chilling. The Nov. issue *Canad. Med. Asso. J.* is the Banting Memorial Number and is notable for illustrating his oils, unfortunately not in color, Best and Collip's historical articles, M. M. Hoffman's note on metabolism of progesterone, and K. C. Fisher's discussion of narcosis which reaches conclusions like those of Loevenhart's (*J. Pharmacol. Exper. Therap.*, 5:239, 1914; *Arch. Int. Med.*, 15:1059, 1915).

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in California and Western Medicine (July issue, pages 108-109; October, pp. 269-270; and November, pp. 287

* The living ex-presidents of the California Medical Association with years of their administration, include: George H. Evans, San Francisco, in 1907; John C. King, Pasadena, in 1910; O. D. Hamlin, Oakland, in 1912; George H. Kress, San Francisco, in 1916; John H. Graves, San Francisco, in 1921; Edward N. Ewer, Oakland, in 1925; William H. Kiger, Los Angeles, in 1928; Morton R. Gibbons, San Francisco, in 1929; Lyell C. Kinney, San Diego, in 1930; Junius B. Harris, Sacramento, in 1931; George G. Reinle, Oakland, in 1933; Clarence G. Toland, Los Angeles, in 1934; Robert A. Peers, Colfax, in 1935; Edward M. Pallette, Los Angeles, in 1936; William W. Roblee, Riverside, in 1938; Harry H. Wilson, Los Angeles, in 1940; Henry S. Rogers, Petaluma, in 1941.

** These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

and 331-332. Some recent excerpts follow:

* * *

Keep It That Way

Many members of the medical profession are going into military service every day. Young doctors just out of medical school, doctors who have barely established themselves in the community, and long-established men who would soon begin to shift the burden of their practice to new partners, are donning uniforms. For the medical men remaining at home, the task will be gigantic. But one and all they are grimly determined that essential medical care will be provided to civilians.

There are many ways in which the layman can help in this medical crisis. He can guard his own physical wellbeing by keeping regular hours and eating and sleeping properly. He can be tolerant if he is kept waiting for an appointment. And he should follow stringently the advice of his physician in order to return himself to full usefulness as soon as possible. These are the tangible ways in which the layman can help the doctor.

In addition, there is a vast intangible aid that we can give our medical men. We can keep in mind the fact that they are a part of the system of private medicine that has doubled the span of life for the ordinary citizen in a comparatively few years. The doctors in the armed forces, just as the ones staying at home, spent years in training and more years interning because competence and efficiency are the very foundation stones of our medical system. There is no taint of "ism" or politics in their blood. Let's keep it that way.—Willows *Journal*, November 27.

* * *

A Living Symbol

Families or parents who have men in military service have something to be thankful for that they probably do not fully appreciate as yet. Our military forces enjoy the most technically perfect, the most humane medical care ever conceived. The best men from the ranks of medicine are in uniform.

An incident that happened recently aboard a battleship "somewhere in the Pacific" may not prove unusual. An enlisted man was abruptly stricken with appendicitis. After a successful emergency operation in the ship's surgery, he found himself attended by his family doctor from his home town. A feeling of confidence and reassurance that flowed into the heart of the patient can well be imagined. Such incidents by repetition will become one of the biggest morale boosters both on the home front and the military front.

The doctor is a vital connecting link between the service men and the country for which they fight. He is a living symbol to the men at the front of the principles of integrity and decency that we are fighting to save.—Carlsbad *Current-Argus*, November 18.

* * *

Protecting Public Health

Civilian medical care in the face of a war born doctor shortage, is a problem. And the doctors, even more so than the civilians, know it. In the first place, the problem is not confined solely to a doctor shortage. There is a shortage of nurses, nurse's aids and labor in general in our hospitals, sanitariums, doctors' offices and all other institutions that help to maintain the physical well being of civilians.

The medical profession is working rapidly and in full coöperation with public and private health organizations to alleviate the situation. They are making definite progress. Additional beds are being installed in critical areas to care for the heavy influx of war workers; plans are being made for establishing hospital service and clinics staffed by doctors working in shifts; steps are being taken to ease the nurse shortage by cutting nonessential tasks of present nurses; and preventive measures, including sanitation, innoculation and isolation are being stepped up. And emergency facilities in event of unforseen disaster, are not being overlooked.

To bring medicine into politics would be disastrous. —Woodlake *Echo*, December 4.

* * *

Don't Shoot, Please

A Washington committee, fearful of a dangerous doctor shortage, has proposed arbitrary halting of further enlistment by medical men in the armed services until a bureau has been created to "supervise and control the drafting and recruiting of doctors." Apparently, pending establishment of the bureau, our soldiers are supposed to keep out of the way of enemy bullets.

The military services are entitled to every doctor they need. And they are entitled to them without awaiting the pleasure of a bureau in Washington. As the American Medical Journal observes: "The least that the nation can do for those who offer their lives in combat is to provide them with the utmost that medicine can offer for the alleviation of the wounded and the prevention of unnecessary death." The armed forces are getting the doctors they need. They are getting them now; the best medical men in the world.

As far as civilian needs are concerned, the American Medical Journal points out that a weekly survey by the Procurement and Assignment Service maintains a constant check on physicians in local communities. This service was created by the President of the United States. It works in close coöperation with the medical profession which does not propose to allow any lapse in the high and hard-won health standards of America.—Industrial *News Review*.—Cypress *Enterprise*, December 9.

* * *

Two Jobs

The action of the medical profession in voluntarily supplying the armed forces with practically the full quota of physicians requested for 1942, has proved that this country can still get a few things done without employment of legislative force. Ernest Lindley, Washington commentator, recently complimented the doctors on the success of their effort when he said: "A few months ago the prospective shortage of physicians in the Army was serious. The job of overcoming this was undertaken by the War Manpower Commission with the coöperation of the American Medical Association. . . . A roster of 176,000 licensed physicians was available from which to draw the military quota of 42,000 for 1942, while preserving as far as possible an even distribution of medical care for the civilian population. This recruitment is still in process. With the year almost three-fourths gone, five-sixths of the quota has been filled."

Actually the performance of medicine in meeting Army needs is not surprising, in view of the history of medical progress in the United States. The health record of our people shows that the medical men are in the habit of achieving results. Right now they are setting to work on the problem of civilian medical care. Unlike other civilian activities, medical care for those at home cannot be put on ice for the duration. Nothing could imperil the war effort more quickly than a breakdown in our health standards.

The doctors have two jobs—one civil, the other military. Both jobs must be done well, and will be under the initiative of the American medical system.—Oakland *Saturday Press*, December 5.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Southern California Medical Society

Aspects of the war as it affects people in Los Angeles will be given consideration at the 107th semiannual meeting of the Southern California Medical Association, which will open a two-day session tomorrow at the County Medical Association, 1925 Wilshire Boulevard.

Tomorrow's session will be devoted to a discussion of disorders of the foot.

"Gasoline rationing is going to cause nearly everyone to walk a great deal more than any of them have been accustomed to. Disorders of the foot will become problems for many thousands of people," Dr. Nelson Paul Anderson, secretary-treasurer, stated yesterday.

More than 600 members of the County Medical Association are now with the Medical Corps of the Armed Forces. Because of this the Saturday afternoon session will be devoted to a symposium on office procedure.

The new plan is designed to increase the efficiency of the doctor in the managing of his patients in his office so as to allow for the giving of medical care to more who need it.

The Saturday morning session will be given over to clinical papers.—Hollywood *Citizen-News,* December 10.

* ** *

Porter Clinic Trustees

Sacramento, Dec. 30.—(INS.)—Appointments, including members of the board of trustees of the Langley Porter Clinic at San Francisco, were made by Governor Olson today.

Appointed to the Langley Porter board of trustees, all to serve until December 23, 1946, were: Lawrence R. Jacobus, M. D., Oakland; and Doctors James F. Rinehart, Charles E. Smith, Karl F. Meyer, all of San Francisco, and Dr. Z. T. Malaby of Pasadena.—San Francisco *Call-Bulletin,* December 30.

* * *

New Transfusion Method Employs Thicker Plasma

Chicago (UP.)—A new method of blood transfusion promises more effective treatment for men wounded on the fighting fronts, the Journal of the American Medical Association said today.

The discovery that albumin in blood plasma (the liquid part) could be injected in more concentrated form than whole plasma provided "a new method of great effectiveness for combating shock from injuries, hemorrhage and burns."

The method was said to be particularly important for treating wounded on the battlefield to reduce the mortality from shock.

Doctors using the albumin serum would need it in quantities only one-fifth as large as those required if whole plasma were used, the Journal said.

Hence its use would facilitate shipping storage and administration.—Burbank *Review,* November 28.

* * *

Medicine Man Knew About Fever Therapy

Los Angeles, Nov. 30.—Artificial fever as a cure for certain diseases is far from a new expedient, according to Dr. Arthur Patch McKinlay, at the Los Angeles campus of the University of California.

A cowboy taken with mountain fever was found in a dying condition by a Wyoming Indian medicine man. With a funnel and a bucket of hot water, repeated injections induced fever and finally the cowboy broke into a heavy perspiration. As the story was told to the professor, this happened about sixty years ago.

In San Quentin in 1926 and 1927, malaria protozoans were given as a cure for paresis, as told by reports reaching Dr. Theodore D. Beckwith, chairman of the department of bacteriology at the University; and as long ago as 1915 in Portland, Oregon, a prominent druggist sold a heat-inducing machine intended to kill germs infecting certain areas of the body.—U. C. *Clip Sheet.*

* * *

Bogus Doctor Is Sentenced to U. S. Prison

Arthur Osborn Phillips, 48, bogus Chico doctor, today was sentenced to serve five years in a federal penitentiary following his plea of guilty to three to four counts charging him with falsifying government records in obtaining employment as a Civilian Conservation Corps physician.

The sentence was imposed by Federal Judge Martin I. Welsh. . . .

The prisoner recently completed a county jail term in Butte County for practicing medicine without a State license. . . .

Phillips admitted he served various penitentiary terms for violating medical practice laws. The terms included one year in Atlanta, Ga., on a narcotics charge.—Sacramento *Bee,* December 10.

* * *

Emergency Recruiting Nations' Death Knell

Los Angeles, Dec. 27.—Due to an unwise recruiting system, France had 1,040,000 fewer births between 1915 and 1919, and in 1940 found herself with 700,000 fewer men between the ages of 20 and 25 years.

This is pointed out by Dr. Constantine Panunzio, associate professor of sociology on the Los Angeles campus of the University of California. He adds that Germany, because of the first world war, had 2,900,000 fewer births, but its growing population rapidly made up the loss.

"England had a far-seeing policy," states Dr. Panunzio. Her recruiting made possible the maintenance of a relatively high birth rate. It deferred married men until the end of 1916, provided family allowances for men who married after enlistment, granted allowances to their wives for each child, and later made similar provisions for drafted married men.

"Consequently, while France lost 1,040,000 births, the United Kingdom, with a population greater by more than 4,000,000 persons, had only 650,000 less than it might have had. England was able to repair the loss. France was not.

"In former wars nations, considering only the emergency of the moment, drew upon all men of military age regardless of marital status and without considering the effect on future manpower."—U. C. *Clip Sheet.*

* * *

Substitute for Quinine Now in Mass Production

Atabrine, substitute for war-scarce quinine, is now being produced at the rate of about a half billion tablets per year. Actual production totals may fall somewhat short of this estimate, according to authorities here. Still there will be plenty of antimalarial units to treat millions of cases.

High speed laboratory machines are spewing tablets of the bright yellow crystals at an ever increasing rate—making bullets to attack malaria to which the armed forces are exposed.

With our men fighting in malaria infested tropics, antimalarial supplies are of vital importance. The periodic fever is not only a serious disease but could dangerously affect combat strength.

"We have four enemies," one military medical authority here declares, "Japan, Germany, Italy—and malaria. There is only one that can lick us. That's malaria. We've got to get results."

Stockpile Dwindles

Many Army doctors still prefer natural quinine, extracted from cinchona bark, to atabrine synthesized in the laboratory. But our dwindling stockpile of quinine was obtained mainly from Jap-held territory in the Far East. Atabrine relieves the shortage.

It should do the job just as effectively as quinine, it is reported by most investigators. There are fewer relapses of cases treated with atabrine, in fact, than when treated with quinine.

Atabrine also compares favorably with quinine in suppression of the disease, clinical reports show. Malarial parasites which hitch-hike from one soldier to another via the mosquito, are eliminated from the blood picture in about a week under either method of treatment.

Only about a fifth as much atabrine as quinine is required for an effective dose. This amounts to about a seventy-second of an ounce of atabrine per day.—*Science Service.*

* * *

Plague Cure Indicated

Yreka, Dec. 15.—Sulfadiazine may prove a definite aid in curing bubonic plague, it was indicated today by Doctors Albert E. Newton, Siskiyou County physician, and Karl F. Meyer, director of the Hooper Foundation for Medical Research at the University of California.

The sulfa drug is being used in the treatment of Donna Mae DeRose, daughter of Mr. and Mrs. Manuel F. DeRose of Hawkinsville, a ghost mining town near Yreka.

Admitted to the Siskiyou County General Hospital early in November, the child was examined by Dr. Newton, who diagnosed her illness as bubonic plague. After being consulted by long-distance telephone, Dr. Meyer confirmed the diagnosis and suggested a procedure for treating the case with large doses of sulfadiazine, while controlling the blood level.

"The purpose of this treatment," Dr. Newton indicated, "is chemically to inhibit the growth of bacteria in her body."

The drug acts to prevent multiplication of the plague bacilli, he explained, and thus aids in enabling white blood cells to combat the germs.

While the patient is greatly improved, her temperature fluctuates and she is not yet out of danger, Dr. Newton stated, adding that while he believes sulfadiazine definitely helped, it is too early to draw a final conclusion.

Siskiyou County had two bubonic plague deaths last year. These fatalities, as well as the present case, were contracted from fleas which had fed on infected rodents. —U. C. *Clip Sheet.*

* * *

Social Medicine

Editor the Chronicle—Sir: The Beveridge scheme for the social revolution of English life was ably handled by both Dorothy Thompson and Chester Rowell in your issue of December 5. I must, however, challenge Mr. Rowell's remarks about social medicine. He says: "There is no reason why it should apply to the self-supporting." There is a reason, and one that goes to the very root of this social revolution, which is coming, all right, both in England and the United States. Thank God, I say, for it. . . .

As medicine is now practiced, the very wealthy are the only people to get a square deal financially, although even they do not necessarily get a square deal as a whole. They have so much money that illness does not affect them financially to any great extent. The indigent get the same treatment from the same surgeons and the same hospitals, but it is flung at them as charity. The most unfortunate are the average people, who, being neither wealthy nor indigent, are bled white.

Now, if specialists and hospitals set their fees according to income, why cannot such fees be paid to them by the government out of a medical reserve built up through the medium of the income tax? Such a scheme, which is evidently what Sir William Beveridge has in mind, would give the specialists and hospitals exactly the same fees, and would spare the patients the frank questions they are asked about their finances at clinics—questions which are in order when put by their elected government, but when put by private persons are merely impertinent. Under this scheme, moreover, a surgeon would be compelled by the law to see a case through once he had operated.

Pacific Grove. J. A. Straker.

—From the "Safety Valve" department of the San Francisco *Chronicle,* December 9.

* * *

Medicos

Editor the Chronicle—Sir: A letter by J. A. Straker on social medicine in your paper exposes a total ignorance of the relations of a medico with his patients. If Mr. Straker could be in the office of one for a month he would learn how wrong his present ideas are. Moreover, he also exposes the very human desire to get something for nothing.

When a specialist acquires a great reputation patients flock to him, so that unless he does something time is too short to permit proper care. The something that he does is to raise his fees and so reduce the number of patients. He takes the same way out as did a famous Philadelphia surgeon whose minimum fee for any operation was $1000. When people objected he said there were hundreds of men in the city who could do the operation just as well as he at a fraction of his fee.

The same with other specialists. Just because they happen to have a reputation doesn't mean that they can take care of patients any better. Sometimes undue reputations are directly due to a flair for publicity and the ability to put on a good act. As a general rule, a patient stands a better chance in an office that is not too crowded as a result of "reputation." Whenever I hear a man say that he "sees" 130 patients a day I know that the word "see" is right.

Mr. Straker doesn't know about the large number of dead beats who refuse to pay after receiving service. The honest suffer for the misdeeds of the dead beat.

Oakland. Roderic O'Connor.

—A Reply in the "Safety Valve" department of the San Francisco *Chronicle,* December 21.

* * *

Dr. Pryor Urges Prenatal and Child Clinics

Prenatal and child welfare clinics are urgently needed in every town, especially in defense areas, if scientific advancements of the past quarter century in the field of immunization, control of communicable disease, better understanding of nutrition and child psychology are to he made available to the mothers of the coming generation, according to Dr. Helen Pryor, medical adviser for women at Stanford University, who spoke at McKinley School auditorium yesterday on the wartime health lecture series.

Dr. Pryor called attention to the fact that there are 73,000 children stillborn every year in this country—tragedies caused by ignorance on the part of the mothers, preventable diseases and other reasons that might have been prevented by proper prenatal instruction, followed by adequate care of the child.

"If our country is to survive, immediate steps must be taken to provide proper education and care for the young mothers and children of today," said Dr. Pryor.

"Italy offers bonuses for large families and Germany condones illegitimacy, in order to increase the population. While this nation will not emulate these examples, it can do much to improve and increase the race hy providing proper care and environment for the expectant mother and her child."

The speaker also described the procedure followed in immunizing infants against whooping cough, diphtheria and smallpox, and declared that nutrition is the most exciting new field of medicine.

Mrs. John J. Garland of Menlo Park, vice-president of the California Congress of Parents and Teachers, spoke on the new war problem, care of the children of war working mothers.

She supported Dr. Pryor's recommendation for the establishment of prenatal and preschool clinics and the education of mothers in proper health supervision of their families—provisions against the time when physicians' service may be unobtainable because of other war needs.

Dr. Ann Aller of Los Altos, instructor in adult education, concluded the panel discussion with a short talk on nutrition.—Redwood City *Tribune.*

* * *

Life Span to Be Stretched to Three Score and Fifteen

The life span probably will be stretched from the present 65 years to 75 years "in our time," said Morris Fishbein, editor of the Journal of the American Medical Association.

Writing in the A.M.A. publication, "Hygeia," Fishbein asserts an increased dissemination of already available medical knowledge is needed to extend the life expectancy of more people to 75 years.

"Most important in prolonging life after 50," he says, "are sound rules of diet and personal hygiene and suitable attention to the detection of degenerative diseases at the earliest possible moment.

"A new specialty is growing in medical science called geriatrics, which means the care of the aged. More and more physicians will become interested in gerontology, a study of the problems of the aged."—San Diego *Tribune-Sun.*

* * *

Native Shack U. S. Hospital

Doctors Operate Under Fire Near Battleline at Gona and Buna

Somewhere in a New Guinea camp.—Nov. 27.—In the jungle clearing a short way behind the Gona-Buna front there stands a crude hut which New Guinea natives built of kunai grass.

Toward that hut comes a steady stream of natives bearing wounded soldiers. They are covered with mud to the waist from ploughing through swampy jungle paths.

The wounded men are Americans and Australians. All day long those natives come in a steady stream. More come through the night, the moonlight glistening on their wet bodies.

Inside the hut there is a crude operating table which the natives built. Beside the table, stripped to the waist, stand Capts. Dr. Charles Lawrence, Chicago, and Dr. Felix Schwartz of Colorado. They operate for hours on Australians and Americans.

By torchlight and to the tune of mortar shelling and the sharp whine of American Brownings and the deep-throated howl of Australian machine guns they wield their scalpels.

They work with deft hands and sure and steady nerves, disregarding their own danger to minister to the wounded. They work swiftly. When one job is finished the patient is removed to make room for another.

Repeatedly the boys ask that some pal be treated first.

The soldiers and doctors continually give a remarkable demonstration of unselfish courage.—San Francisco *Examiner,* December 7.

The muscles of a human being account for 40 per cent of his body weight.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Statute of Limitations in Malpractice Actions: Time Within Which Suit Must Be Brought to Recover for the Negligent Leaving of Foreign Matter in a Patient's Body

It is a general rule that a court action by a patient against a physician and surgeon for injuries sustained by reason of the negligent or unskillful treatment administered by the physician is an action sounding in tort and is not based upon the contractual relationship existing between physician and patient. This being so, ordinarily, as in the case of other torts, an action for malpractice is barred under the provisions of Section 340 of the Code of Civil Procedure within the relatively short period expiring one year after the date of the injury. There are, however, recognized exceptions to this rule which, under certain circumstances, extend the time within which an action may be commenced. The courts have been particularly liberal in allowing a patient to prosecute a suit more than one year after the inception of the alleged injury in cases where the physician or surgeon has negligently left some foreign matter, such as a surgical sponge or skin clip, in the patient's body. (See Medical Jurisprudence articles in CALIFORNIA AND WESTERN MEDICINE, March, 1937, and February, 1939, on this same subject.)

It has been held where some such foreign object is allowed to remain within the body after an operation, that the failure to remove is the negligent act which warrants a malpractice action, that the obligation to remove is a continuing obligation and that the negligence does not terminate until the article is in fact removed. Each days' failure to remove gives rise to a new cause of action. On this theory, it is then determined that the statute of limitations does not begin to run from the date of the operation and an action for malpractice is not barred at the expiration of one year from the date of the operation. Again, in the case of *Trombley v. Kolts,* 29 Cal. App. (2d) 699, the court further extended the time within which a patient may sue in such cases by holding that where the relationship of physician and patient continued after the discovery of a skin clip left within the patient's body and where the physician advised the patient that no harm would result from allowing it to remain, the statute of limitations had not run and an action by the patient was not barred even though commenced more than one year after the discovery of the skin clip.

A recent decision of the District Court of Appeal, *Pellett v. Sonotone Corporation,* 55 A.C.A. 196, is another example of the court's tendency in this type of case to permit an action more than one year after the initial negligent act or omission occurs. The *Pellett* case involved an action against the defendant corporation and its agent, a dentist, who had made a plaster impression of the plaintiff's ear in order to properly fit plaintiff with a hearing device which the defendant corporation sold. In March, 1939, the dentist poured plaster into the plaintiff's ear allowing it to remain for a few minutes and then removing the resulting plaster impression. On his way home from the dentist's office, the plaintiff complained to another agent of the corporation that his ear hurt, but was informed that such pain was to be expected. Again, in October, 1939, the plaintiff complained to this same agent, but was told that the pain could be expected until he accustomed himself to wearing the hearing device. In February, 1940, the plaintiff consulted a physician in regard to his ear and was advised that there was a hard foreign substance in his ear which upon removal was ascertained to be bits of plaster and cotton which the defendants had negligently failed to remove at the time the plaster impression had been taken. In May, 1940 (one year and two months after the occurrence of the injury), the plaintiff commenced an action against the Sonotone Corporation and its agent, the dentist, who had taken the impression. The court held that this delay was no bar to the action and that it could be successfully prosecuted at such time, stating the rule to be that in an action to recover damages for negligently failing to remove from a human body a foreign substance which defendant had placed there, the *statute of limitations commenced to run from the date the plaintiff discovered, or from the use of reasonable diligence should have discovered, that the foreign substance had not been removed,* and the statute of limitations does not commence to run from the date the substance was placed in the human body. Although this action did not involve negligence on the part of a physician or a surgeon, the court applied the same rules as in the decisions above discussed.

Another fairly recent case, *Ehlen v. Burrows,* 51 Cal. App. (2d) 141, interpreted this extension of the statute of limitations as being applicable not only to a situation where some foreign matter is allowed to remain in the body but also to a case where a surgeon left broken roots in the jaw of a patient after removing several teeth. The court held that where it did not appear that the patient discovered the roots or should have discovered them more than one year prior to the commencement of the suit, her action to recover damages for the injuries sustained was not barred. On its facts, this case seems to extend the one year statute of limitations in all cases where a surgeon fails to remove some part of the human body which he has undertaken to remove by the operation performed. If this is true, then the one year statute will not commence to run in such cases until the patient discovers, or in the exercise of reasonable diligence should have discovered, the negligent omission of the surgeon.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 1, January, 1918

EXCERPTS FROM EDITORIAL NOTES

California Doctors in Service [January, 1918].—On another page of this issue of the JOURNAL appear the names of those physicians of California who have been commissioned in the government medical services. The list is incomplete and may contain inaccuracies. Partly to remedy these two faults, it is published. It is requested that each reader will particularly scrutinize it and report at once any omission or inaccuracy noted. The latest figures now available cover only through the early part of November. It is requested that all commissions accepted up to December 31, 1918, be reported at once if not already on this list.

The list is published, however, not solely for the sake of obtaining a corrected roll, but also for the more noble purpose of doing honor to those of our number who have been so fortunate as to receive commissions. Their honor is to some small extent reflected on us who stay behind for the time. We are proud of them and we are proud to belong to their profession. As they have gone and we stay behind, it behooves us to do our bit with a right good will that their sacrifice be not fruitless, that their exertions be not neutralized by lack of enthusiastic and effective support. From time to time, various avenues of home service have received comment in the JOURNAL. . . .

American Manufacture of Salvarsan.—The Federal Trade Commission has entered orders for the license of three firms to manufacture and sell salvarsan under the American name of "arsphenamine." The control of standards and quality of product will devolve upon the Federal Public Health Service. . . .

Periodic Physical Examination.—It is such an old story. Every doctor knows it. Most patients know it. But the trouble is that he and they are too busy to remember it. Both are prone to let well enough answer. No man can get himself in sufficient perspective to see his own beginning physical and mental infirmities. Few can do it for their moral shortcomings. Even the doctor himself does not always elicit the significant history of a little undue weariness, or slight breathlessness, or hazy vision, or inability to make physical and mental adjustments in reflex fashion. . . .

Every physician should preach and practice periodic medical examination, at least once yearly when in apparent health. It is reasonable, and represents the best development of the physician's art, the prevention of disease in the individual.

The Conservation of Vitamins.—With the present concern over food supply, comes the pitfall for both institutions and individuals of a dietary deficient in vitamins. We do not know what vitamins are. [Year, 1918.] The name is doubtless a misnomer. Accessory food substances necessary for growth and maintenance of healthy

(Continued in Back Advertising Section, Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"An extension of California's sterilization program, to include persons adjudged by courts to be psychopathic delinquents and sexual psycopaths, was recommended yesterday at a conference of heads of 16 State institutions, including Dr. G. Max Webster, director of Patton State Hospital. . . . The extension of the sterilization program would require specific legislation, said Dr. F. O. Butler, acting director of institutions, because the attorney general's office has held that the present sterilization program cannot legally include psychopathic delinquents or sexual psycopaths. 'There may be some public criticism of our action (in recommending extension of sterilization),' Dr. Butler said, 'but we must face it. Psychopathic and mentally-defective delinquents, and sexual psycopaths, should not be turned loose on society in their present state.'..." (San Bernardino *Sun,* Nov. 13, 1942.)

"Several weeks ago, the Napa City council advised the Napa County Medical Association that the $5-day rate and $10-night rate for examining drunk drivers was too high, and urged that the rate be reduced. This week, the physicians of the Victory Hospital staff announced to the council that the rates for examining drunk drivers have been set at $10 for calls from 6 a. m. until midnight, and at $12.50 for calls after midnight. The new rate is double the old rate for daytime and $2.50 more for night calls." (Napa *Journal,* Nov. 20, 1942.)

"Criticism of Dr. S. J. Francis, Santa Ana chiropractor, for stating publicly that the International Chiropractors Association had petitioned Major General Hershey to defer members of this profession, and permit them to serve on the home front, is not justified, Cash Asher, public relations director of the Association, said in Davenport, Iowa, today. Asher said that the Association had requested Hershey to recommend to draft boards the deferment of chiropractors, since there is no provision in the military establishment at this time for their services. He declared that Hershey had recommended to draft boards that osteopaths be deferred, because osteopathy, like chiropractic, is not included in the healing services of the Army or Navy. He added that, obviously, the same regulation should apply to chiropractors as applies to osteopaths. . . ." (Santa Ana *Register,* Nov. 9, 1942.)

"Justice of the Peace George DeWolf ruled today that defense witnesses in the trial of Grayson M. Martin, 59, of 315 First Street, charged with violating the State health code by selling sea water at $10 a gallon as a remedy for several major diseases, may testify whether they felt better after taking the preparation. . . . The State rested late yesterday after introducing the testimony of Henry Fliedmer, 622 South Eleventh Street, who went to the district attorney after buying one bottle.

(Continued in Back Advertising Section, Page 38)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

WARTIME BOOM IN BABIES



Photograph Camp prenatal support (skeleton indrawn)



Today, more babies are on the way than in any time during the last 20 years! Naturally, there is a corresponding rise in the need and demand for prenatal supports.

The S. H. Camp and Company has developed over a period of more than 30 years—*a complete series* of maternity supports . . . each type scientifically designed and constructed . . . each type giving accurate support to the abdomen, pelvic girdle and spinal column.

In fact, not a single detail which will add to their clinical value has been neglected.

That these garments successfully measure up to the most stringent clinical requirements is evident—since they carry the approval of many leading gynecologists and obstetricians throughout the world.

The Camp series of prenatal supports comprise models suitable for all types of build. Patients are asked to return each month for adjustment of their prenatal supports. This service is given free of charge by all Camp-trained fitters.

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BOOK REVIEWS

(Continued from Front Advertising Section, Page 20)

contribution that individual foods may make with respect to the needs for protein, calcium, iron, vitamin A, thiamine, riboflavin, nicotinic acid, and ascorbic acid. A feature of these graphic presentations is that the values are presented in terms of the proportion of the daily requirements which are supplied by typical servings of each food. The requirements selected are the Recommended Daily Allowances of the Food and Nutrition Board of the National Research Council. The charts show, for example, that a serving of about 3½ ounces of cooked greens (beet, kale, chard, mustard, spinach, turnip), will supply more than 10,000 International units of pro-vitamin A, the daily allowance of which is 5,000 International units. An orange of average size, or half a grapefruit, or a serving of fresh strawberries will supply the 75 milligrams of ascorbic acid which is considered to be a desirable intake of vitamin C. It is interesting to note the unique value of milk as a source of calcium, protein and ribolflavin. There is a descriptive paragraph or two about each of the charts. In addition the booklet reproduces the table of Recommended Dietary Allowances and also provides the values of Minimum Dietary Requirements developed by the Food and Drug Administration for purposes of labeling special dietary foods. This little essay thus provides considerable factual information about foods as sources of the dietary essentials.

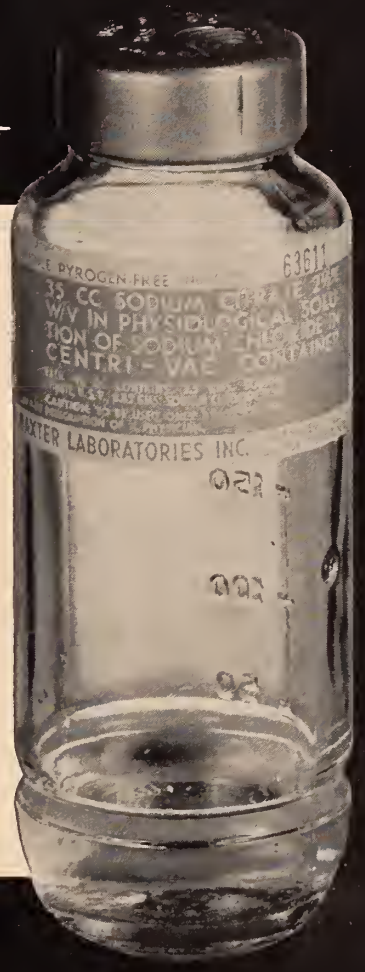
Milestones in Medical History

6

1940

THE *Baxter* CENTRI-VAC

FOR MAXIMUM PLASMA YIELD



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TWENTY-FIVE YEARS AGO

(Continued from Text Page 54)

nutrition would better describe them. Yet the name has achieved an accepted position in popular and scientific nomenclature, and serves a useful function. We at least know that certain diseases can be prevented and cured by relieving a dietary fault of which the specific nature is unknown, although what we are pleased to call vitamins are lacking. . . .

The Venereal Silence.—It is full time that the old superstitious fear of naming syphilis and gonorrhea in public and in private be abolished. How are they to be fought if they must always be unnameable? Why should a current Government publication even speak of "virulent blood poison," when it means syphilis? How many newspapers will use the correct names for these diseases, when they are unashamed at the bold portrayals of the quack advertisers, and patent medicine testimonials, and police court dregs which are spread on a different page? How many public speakers will call them by name when need arises? Why should it be shameful to know their peril and to study their prevention?

The splendid policy and work of the California State Board of Public Health in protecting the Army camps from venereal disease has been noted and cannot receive too high commendation. The splendid policy and work of the Army and Navy authorities in the same direction deserves the commendation and support of every American. We have, and surely hope to have in the future, a military force unique in history for its freedom from venereal disease. . . .

(Continued on Page 28)

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I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

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I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

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I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the County of ——— State of California, and more particularly described as follows, to-wit:

* * *

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I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

Editorial Comment.—The Principles of Ethics of the American Medical Association states that it is "derogatory to professional character for physicians to accept rebates on prescriptions or surgical appliances." If this is true, then any doctor who receives a rebate from the maker of artificial limbs, trusses, belts, etc., is acting in an unethical and unprofessional manner.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Present Status of Health Insurance in California," by René Bine, M. D., San Francisco, Chairman of the Committee on Health Insurance of the State Society.—The Social Insurance Commission of the State of California has proposed an amendment to the constitution which, if passed, will enable the legislature to establish a real insurance system. The legislature does not meet in 1918. Nothing can be done therefore towards passing any Health Insurance bill until 1919, provided the amendment is carried in November, 1918. . . .

Your committee published its first report in the June, 1917 issue, and to this your attention is again called. . . .

From an Article on "The Venereal Situation Among the Forces at War," by John C. Spencer, M. D., San Francisco.—It is the concensus of opinion that venereal diseases are responsible for more disabled and inefficient fighting men than all other diseases combined. This statement is readily confirmed by reference to Governmental reports from the military authorities of the principal warring nations.

(Continued on Page 30)

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

As a basis of computation for an estimate of the ravages upon human life and health, no better testimony is available than that presented in the Lettsomian oration by Sir William Osler. His figures are based on the English experience:

"In 1915, while nine soldiers died every hour, during the same period twelve babies died to the scandal of the country. . . . The gonococcus is the greatest known preventer of life. . . . A conservative estimate of the women sterile from a gonorrheal infection is 50 per cent. From the same cause 30 to 40 per cent of human beings are rendered congenitally blind. Add to these the chronic pelvic mischief and the unhappiness of sterile marriages . . . and the gonococcus is the king among germs. . . . In 1915 syphilis was the cause of 20 000 still-births; between 15,000 and 20,000 babies died from the same cause during the first year of their life. . . . Out of 562,000 deaths from all causes, 10,000 were from syphilis of the vascular system. The grand total of deaths from this cause amounted to 60,000. . . . The last obtainable figures as to the percentage of venereal diseases in the British army showed syphilis, 21,000; gonorrhea, 71,000; and chancroid, 6,000."

From an Article on "Appendicitis in Childhood—Study of One Hundred Cases," by Langley Porter, M. D., San Francisco.—Appendicitis is a condition far from rare in childhood, but as common as it is, its timely recognition is one of the most difficult tasks presented to the medical man for solution. The classical signs which in adult patients render the diagnosis relatively easy, fail or are

(Continued on Page 32)

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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

obscured when the attack occurs in early life. Fever, vomiting, constipation and abdominal pain are all frequent events during the child's first years, events which may be indices of either trivial or tragical pathological disturbances. Leucocytosis, also, may mean much or little at this period, as white cell counts are increased very materially under very slight provocation and fluctuations in the counts are positive and frequent. The difficulty in eliciting dependable replies from children minimizes the value of subjective symptoms, the very group of symptoms which is most weighty in diagnostic consideration when we are dealing with adult patients. . . .

From an Article on "Rat Bite Fever with Report of Two Cases," by F. F. Gundrum, M. D., Sacramento.—Rat Bite Fever is an acute contagious disease acquired through being bitten by an infected rat, and characterized by recurring paroxysms of fever, a striking blue-red rash, and a strong tendency to transitory paralysis of the lower extremities. . . .

Case Reports: During June, 1916, there were admitted to the Sacramento County Hospital two patients, one of whom had a classical, the other a so-called abortive attack of Rat Bite Fever. . . .

From an Article on "A Conservative Physician's View of the Proposed Social Health Insurance Schemes," by S. E. Simmons, M. D., Sacramento.—Conditions of society, as well as industry, are constantly changing, and the government seeks to formulate laws which are founded upon theories which seem tenable and applicable to present conditions. But the question arises in our mind, how far can the State, in its legislation, advance between the extremes of Individualism and Socialism? . . .

We all know what has been done along these lines in England and Germany, but we make a gross error in presuming that industrial conditions are at all the same in these countries, as in California. It is stated by the Chancellor of the Exchequer, that 57 per cent of the wage earners in the kingdom earn less than twenty-five shillings a week; i. e., $5.00.

In Germany, more than one-fourth of the population come under the head of compulsory insurance, both accident and health, and as the limit in that country for insurance is two thousand marks ($500.00) per year as wages, it figures out that one-fourth the population is making $9.50 a week or less, vastly less, I should say. Can we compare these wages figures with conditions existing in California? Does it occur to any of us that 25 per cent of the population in California is getting less than $5.00 a week as in England, or less than $9.50 a week as in Germany; though facts and figures are not at hand, it is very much to be doubted if such is the case. . . .

In this society a little more than a year ago, requests were made for a list of those who were willing to do the State's work for a fee as stipulated, and with which you are familiar, very much less than the fees heretofore charged for the same class of work. I know of no better way than to quote some of the figures from the California Commission, to show how ridiculously low this fee was, per case tended. In 1914, there were 62,211 Industrial accidents in California necessitating medical treatment. For the medical services (*including hospital charges*), the physicians and surgeons of California received $730,178. This averages a little over $11.50 per case.

(Continued on Page 34)



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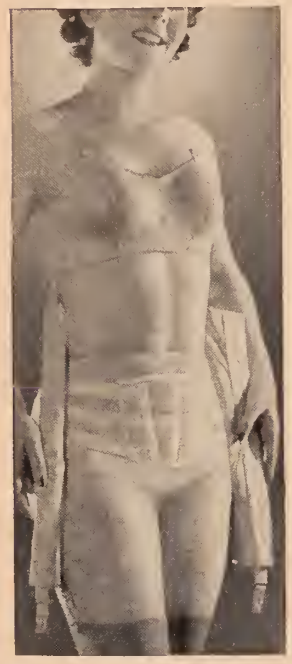
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(Continued from Page 32)

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From an Article on "Exfoliative Cystitis," by Granville MacGowan, M. D., Los Angeles.—Exfoliative Cystitis is a pathological process apparently arising in the course of vesical infection without any consistently definite or specific cause though passive congestion with ammoniacal decomposition of the urine are present. . . .

From an Article on "Internal Hemorrhoid Operation and After-Care Under Quinine-Urea Hydrochloride Anesthesia," by E. Jay Clemons, M. D., Los Angeles.—In presenting this paper I do so with no intention of adding anything new to medical literature, but simply because of the fact it is my belief this technique comes as near fulfilling the golden rule of surgery by "relieving our patient—pleasantly, safely and quickly," as is possible with our present knowledge. . . .

From an Article on "Some Remarks on Laryngeal Affections," by H. B. Graham, M. D., San Francisco.—In no branch of medicine is there exhibited more neglect on the part of the medical men than in diseases of the larynx. A hoarseness may go on for months even under the eyes of a specialist, and the patient told he has some insignificant affection that will soon pass off without even

(Continued on Page 36)



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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

an examination being made. The cause of this is easily seen when one watches the methods pursued in the education of the average medical student. . . .

From an Article on "Report of a Case of Otitic Meningitis," by Edward Cecil Sewall, A.B., M.D., San Francisco. (From the Ear, Nose and Throat Clinic, Stanford University Medical Department.)—While the following case presents a picture that is quite typical of the course of a streptococcus mucosus infection, it is still not out of place to be reminded of the insidious character of that organism. Also, although the clinical signs of meningitis were not out of the ordinary, there were some interesting facts brought out in the repeated examinations of the spinal fluid. Then, too, it is rather the exception when we cannot trace the pathway of the lesion to the meninges either in the autopsy room or laboratory. . . .

From an Article on "The Care of the Functioning Breast," by Frank C. Ainley, M.D., Los Angeles.—It is generally admitted that the natural food for the human infant is human milk, that breast-fed babies are more likely to live than the artificially-fed, and that, as a class, they are healthier, more vigorous, and more resistant.

Few appreciate, however, how much greater the mortality is in artificially-fed than in breast-fed infants. Statistics show that 75 to 90 per cent of all deaths during the first year are in artificially-fed children. The younger the baby the higher the mortality. About one-

(Continued on Page 38)



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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 54)

and that of two State health inspectors. The latter said Martin claimed the sea water would be effective against diabetes, high and low blood pressure, heart trouble, anemia, overweight and rheumatism." (Fresno *Bee*, Nov. 19, 1942.)

"The District Attorney's office, in coöperation with the State Board of Medical Examiners and the local Health Department, has moved into a new field in its war to curb the spread of venereal disease, it was disclosed Saturday. Assigned to the job by District Attorney

(Continued on Page 40)



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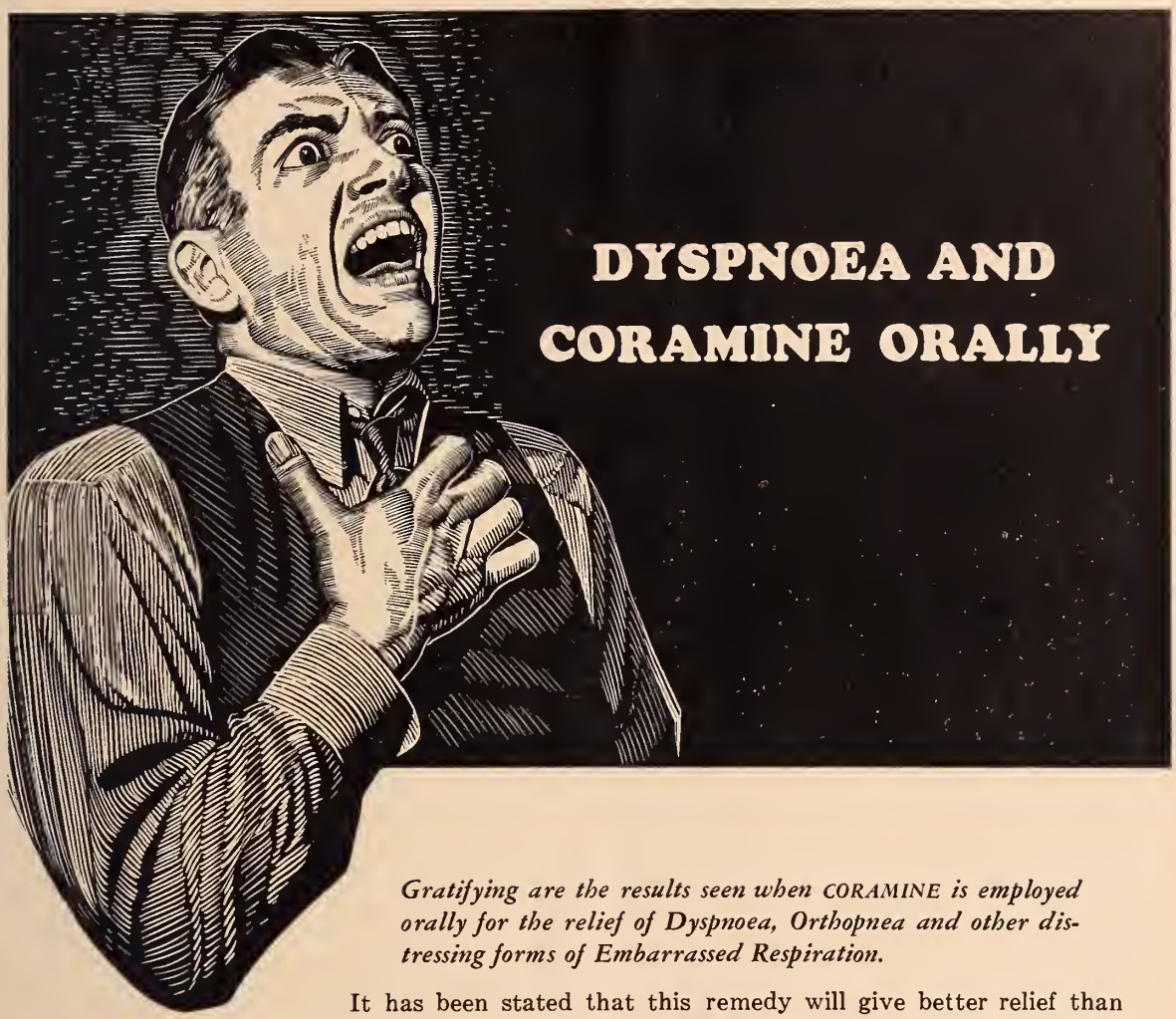
BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

Matthew Brady, Deputy Ben K. Lerer has completed a city-wide investigation of Chinese herbalists, many of whom, Deputy Lerer states, have been illegally prescribing for communicable diseases. . . . 'We have evidence,' Lerer said Saturday, 'that herbalists have been giving medical treatment to members of our armed forces which has only led to the spread of venereal disease and not its cure.' Working with Deputy Lerer in the investigation were Joseph Williams of the State Board of Medical Examiners, Health Director Geiger and Richard Koch, director of the Health Department's venereal disease division." (San Francisco *Recorder*, Nov. 16, 1942.)

"Police Judge Melvin K. Gibbs late yesterday took under advisement the case of Archie B. Thomas, 56, of 158 North Van Ness Avenue, one-time prohibition undercover man, charged on four counts with fortune telling, after two police operators testified that Thomas accepted money for predicting they would find a lost son. The defense set up the claim Thomas is a minister, and receives no compensation for his services as a counsellor on moral and spiritual problems other than voluntary donations. Thomas, under cross examination by City Attorney C. M. Ozias, admitted he never attended a theological seminary and that any knowledge he has of theology and philosophy is self-taught. The defense submitted, as exhibits, Thomas' alleged certificate of ordination as a minister of spiritualism in 1932 and a State charter of incorporation as a church for the Truth Seekers Center of which Thomas claims to be a prominent member. Gibbs, however, indicated his decision would be based largely on the question whether even duly-ordained ministers are permitted by California law to predict the future, with or without compensation. . . . On the second visit Thomas wrote a prescription for one of the operators who complained of illness, although no testimony was introduced to show that Thomas ever has practiced medicine. Under cross examination, Thomas admitted writing the prescription which he said called largely for vitamin tablets and liver pills. The police operator did not take the preparation. On this second visit, one operator testified, Thomas asked if he had not forgotten something when he prepared to leave without paying the same fee as on the previous visit. . . . Thomas told one visitor he is a Brahmin, a member of the pirestly-caste of a nonChristian religion." (Fresno *Bee* Nov. 20, 1942.)

" 'He told me I had kidney trouble from having eaten too many cakes and cookies in my childhood, and that for $150 he could do a great deal for me.' Medical Board Investigator Nellie Guenther didn't go in for the treatment; instead she gave that testimony today in Municipal Judge Leroy Dawson's court, where 'Dr.' Howard Whiteside went to trial on charges of violating the Medical Practice Act. Miss Guenther said she was accompanied to Whiteside's place at 800 West Seventh Street, August 26, by another investigator, Hazel Hotz, where the middle-aged defendant had advertised himself as 'the world's greatest scientist of the mind.' Miss Guenther said she was told the treatment would consist of 'electricity, touch and herbs.'" (Los Angeles *Herald and Express*, Nov. 13, 1942.)



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[1]Lankford, J. S., "Coramine," Clinical Medicine & Surgery, 37, 670, 1930.

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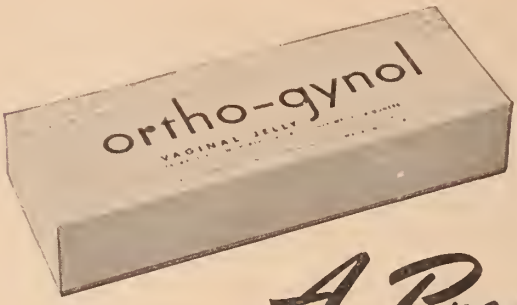
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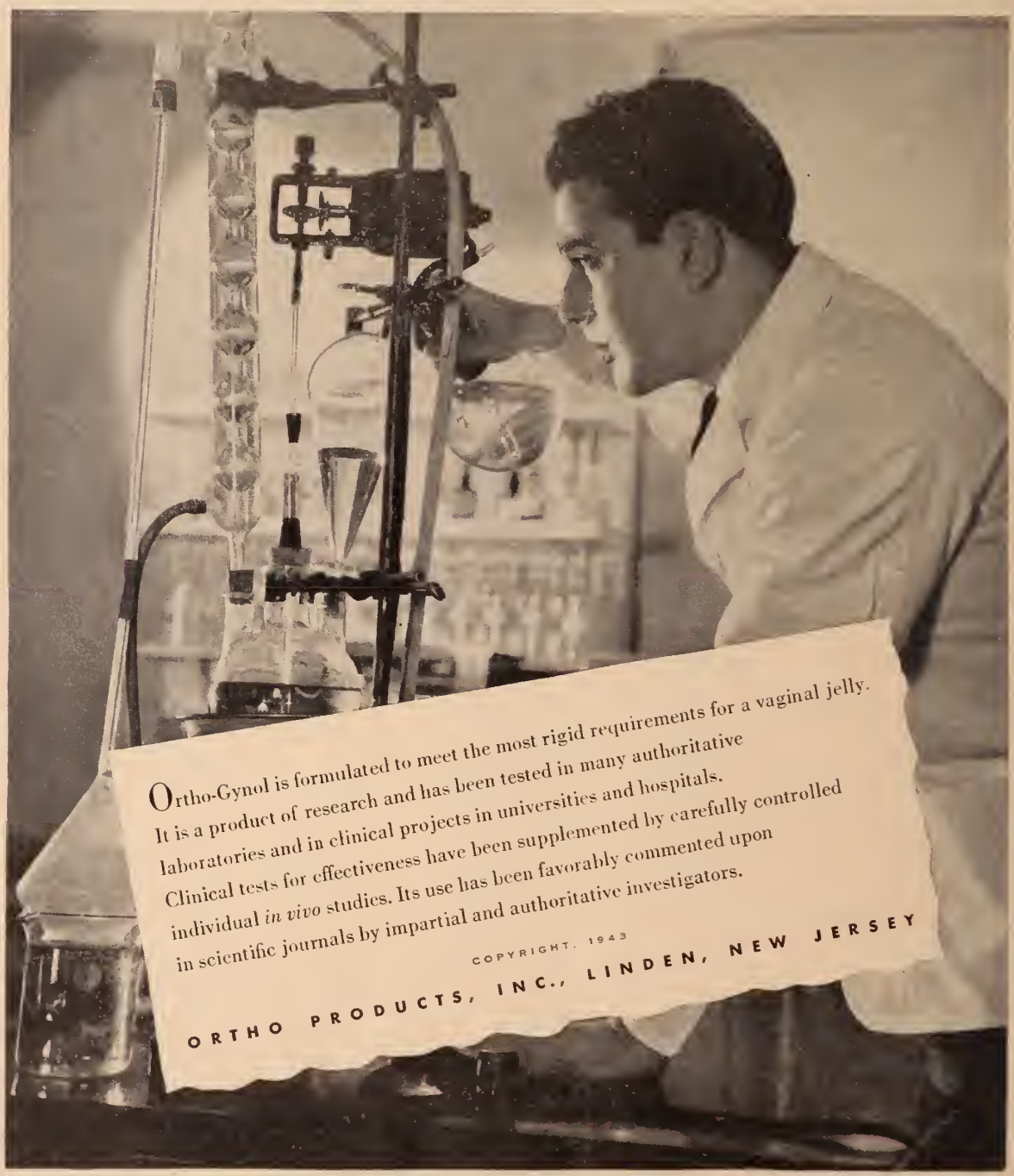
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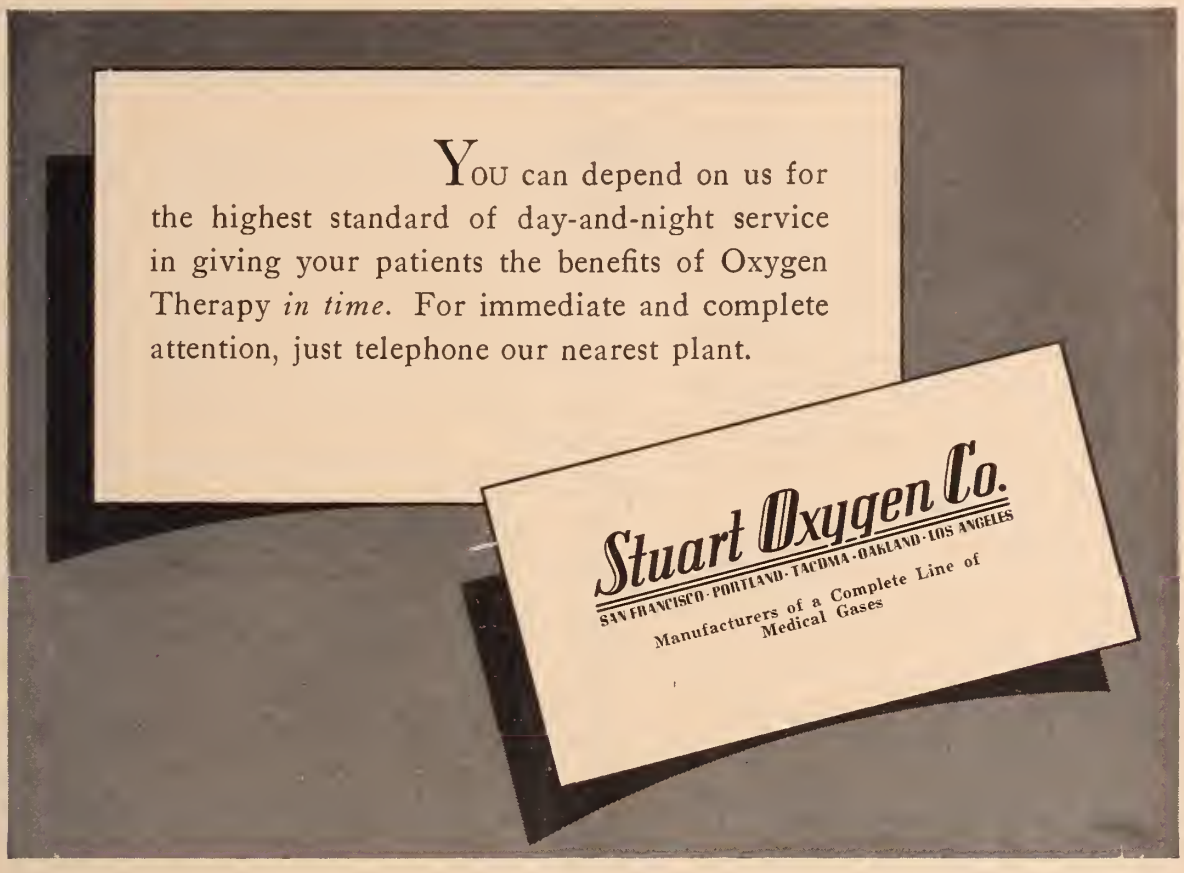
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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, Floyd A. Burger, Box 193, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.*
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2212 W. 3rd Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. O. Weiskotten, 2130 Fourth Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Albert K. Merchant, Dameron's Hospital, Stockton.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, 1009 Morro, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie, 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 H Street, Marysville.
Secretary, Joseph H. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising Page 6)



(Continued from Page 3)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.
Sacramento—1020 N St., Phone 2-4711.
Los Angeles—State Office Building, 217 West First Street, MAdison 1281.

President, Elmer Belt, Los Angeles
Director, Bertram P. Brown, 603 Phelan Building, 760 Market Street, San Francisco

California Northern District Medical Society

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Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.
Los Angeles, 906 State Building.
Sacramento, Business and Professional Building, 1020 N Street.

Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside
Secretary, Nelson Paul Anderson, 2007 Wilshire Blvd., Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

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Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
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BOOK REVIEWS

BOOKS RECEIVED

How to Win and Keep Health with Foods. By Victor H. Lindlahr, Editor, Journal of Living, President, National Nutrition Society; Lecturer on Health and Nutrition, Radio Stations from Coast to Coast. Paper. Price $1.00. Pp. 128. New York: National Nutrition Society, Inc., 1942.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1941, with the Comments that have Appeared in the Journal. Cloth. Pp. 187. Chicago: American Medical Association, 1942.

New and Nonofficial Remedies, 1942. Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1942. Issued Under the Direction and Supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Austin E. Smith, M.D., C.M., M.Sc., Editor. Cloth. Pp. 672. Chicago: American Medical Association, 1942.

Fundamentals of Psychiatry. By Edward A. Strecker, M.D., Sc.D., F.A.C.P., Professor of Psychiatry and Chairman of the Department, Undergraduate School of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania Hospital; Attending Psychiatrist, Psychopathic Division, Philadelphia General Hospital. Cloth. Price $3.00. Pp. 201, with 15 illustrations. Philadelphia, Montreal and London: J. B. Lippincott Company, 1942.

Mental Illness: A Guide for the Family. By Edith M. Stern, with the collaboration of Samuel W. Hamilton, M.D. Cloth. Price $1.00. Pp. 134. New York: The Commonwealth Fund, 1942.

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BOOKS RECEIVED

(Continued from Page 7)

The Eye Manifestations of Internal Diseases. By I. S. Tassman, M.D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital, Philadelphia, Pa. Cloth. Pp. 542, with 201 illustrations, including 19 in color. St. Louis: The C. V. Mosby Company, 1942.

The Time of My Life. A Frontier Doctor in Alaska. By Harry Carlos De Vighne. Pp. 336.

Mental Health in College. By Clements C. Fry, M.D., Lecturer in Psychiatry and Mental Hygiene and Psychiatrist to the Department of University Health, Yale University, with the collaboration of Edna G. Rostow, Research Assistant in Psychiatry and Mental Hygiene, Division of College Psychiatry and Mental Hygiene, Yale University. Cloth. Price $2.00. Pp. 365. New York: The Commonwealth Fund, 1942.

Regain Your Figure. How to Recover the Figure after Childbirth without 'Strengthening' Exercises. By Lt.-Col. J. K. McConnel, D.S.O., M.C., Member of the Chartered Society of Massage and Medical Gymnastics, with a foreword by Cedric Lane-Roberts, M.S., F.R.C.S., F.C.O.G. Illustrated by Warwick Lendon. Cloth. Price $2.00. Pp. 128. Cleveland: The Sherwood Press, 1939.

Religion and Health. By Seward Hiltner. Cloth. Price $2.50. Pp. 292. New York: The Macmillan Company, 1943.

The Answer Is . . . Your Nerves. By Arnold S. Jackson, MD., F.A.C.S., with a chapter by the Rev. Edwin O. Kennedy. Cloth. Price $2.00. Pp. 197, with illustrations by Evelyn Lipman. Madison, Wisconsin: Kilgore Printing Company, 1942.

BOOK REVIEWS

Civilian Health in Wartime. By Francis R. Dieuaide, M.D., Associate Professor of Medicine, Harvard Medical

(Continued on Page 16)

THE CAUSE *Obscure*

"The ultimate cause of peptic ulcer is unknown . . ."

Winkelstein, Asher: Rev. Gast.
May-June, 1942, p. 174

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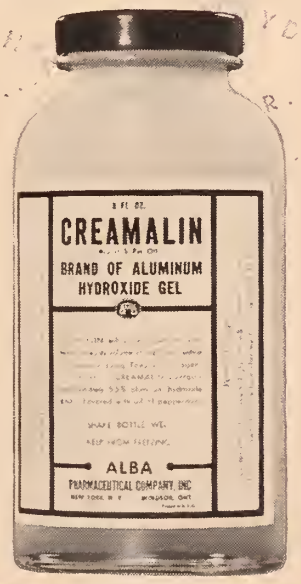
Emery, E. S. Jr., and Rutherford,
R. B.: New Eng. Jrnl. Med.
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Announcement by Frederick Stearns.—Appointment of Rafael C. Brewster as general salesmanager in charge of sales and advertising for Frederick Stearns and Company, is announced by Erwin F. Fauser, president. Stearns is one of the oldest and largest pharmaceutical manufacturers. Brewster's wide experience includes sales direction for several large firms. He also has been a member of two advertising agencies and of the staff of Cosmopolitan Magazine. His appointment, President Fauser said, is in line with Stearns' program of expansion of research and products.

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BOOK REVIEWS

(Continued from Page 10)

School, Massachusetts General Hospital. Cloth. Price $2.50. Pp. 327. Cambridge: Harvard University Press, 1942.

Today the lay literature teems with numerous articles concerning civilian health. Francis R. Dieuaide, M.D. is Associate Professor of Medicine in Harvard Medical School and has brought off an excellent volume dealing with this subject. He calls attention to the fact that health grows in significance in proportion with the duration of the war in which most of the peoples of the world are now engaged. Few among us have an adequate conception of the sacrifices which may be necessary before victory is won. The preservation, even the improvement of health should be one of our foremost aims during the war. This book represents an attempt to provide the general reader with a statement, in broad but definite outline, of the varied aspects of health in the United States in relation to the war. The point of view is that of positive health.

The author took up his subject matter under the following headings: Health and the Impact of War Upon It; The Nutritional Background; Increased Strength Through Better Diets; Safety from Infectious Diseases; Shelter and Raiment; Mother and Child; The Aging and the Aged; Occupation and Recreation; About Our Doctors and Nurses; Mental Calm and Vigor; Epilogue-Morale and the Second World War; Suggestions for Further Reading.

The Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M.D., Orthopedic Surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price $3.00. Pp. 424. Chicago: The Year Book Publishers, Inc., 1942.

If the complexion of this summary of the world's

(Continued on Page 18)



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Designed for the convenience of the general practitioner, and keeping pace with the progress of medicine in every field, this new Hughes is an authoritative guide to the many advances in diagnosis and treatment. Much new material is presented on chemotherapy, vitamin therapy and endocrinotherapy. Various problems relating to the strain and stress of present day life are considered. Important advances in treatment by sulfonamide compounds are given. Poisoning by war gases, and up-to-date treatment is discussed. The essential facts on diagnosis, etiology, symptoms, treatment, etc. are grouped in convenient paragraphs for reference. Special sections on the skin and on nervous and mental diseases are included.

Revised and Edited by Burgess Gordon, M. D., Jefferson Medical College, Philadelphia. 36 Illus., 796 Pages, $5.75

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOOK REVIEWS

(Continued from Page 16)

literature on orthopedic and traumatic surgery seems overtinged with war coloring, it could hardly be avoided. The author states: "There should not be and there are no real grounds for conflict between the traumatic surgeon and the orthopedic surgeon. In fact, no one who aspires to practice orthopedic surgery should do so unless, and until, he is a competent general surgeon, and, by the same token, anyone practicing traumatic surgery must be skilled in certain procedures of the orthopedic specialist."

Eat What You Want; A sensible guide to good health through good eating. By W. W. Bauer, M.D., Director, Bureau of Health Education, American Medical Association, Associate Editor "Hygela"; and Florence Marvyne Bauer, with an introduction by Morris Fishbein, M.D. Cloth. Price $2.00. Pp. 263. New York: Greenberg, Publisher, Inc., 1942.

The volume, "Eat What You Want" has as its author, W. W. Bauer, M. D. of the Bureau of Health Education of the American Medical Association, who has had many years' experience in presenting scientific topics to the lay public. The editor of the *Journal of the A.M.A.*, Morris Fishbein, M. D., gives an introductory note and calls attention to the fact that the National Conference on Nutrition for Defense served to focus the attention of the people of the United States on the fact that we have more food available to our nation than has any other country in the world, but that with this abundance, we eat, for the most part, unintelligently. Fortunately, the human being is built with factors of safety which help him to overcome the results of his ignorance. Our

(Continued on Page 20)

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Chamberlain & Sokolow (American Heart Journal, February, 1942) state:
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BOOK REVIEWS

(Continued from Page 18)

knowledge of nutrition is relatively new, since most of the great discoveries in this field have been made in the past twenty-five years.

The chapter divisions include the folowing: Everybody's Dieting; Eating to Live; Living to Eat; Calorie Crazy Quilt; First Eat What You Should; What, No Vitamins?; Dressing Up the Diet; To Market We Go; Let's Eat Out; The Funny Food Faddist; If You Carry Your Lunch.

Bonnie's Baby Brother and How He Grew. By Elizabeth Ryder Montgomery. Photographic illustrations by Ralph W. Berry. Foreword by Clara Savage Littledale. Cloth. Price $2.00. Pp. 95. Philadelphia and New York: Frederick A. Stokes Company, 1942.

This little volume of some 95 pages is profusely illustrated with the photographs of a child from the time of birth up to the age of one year. Informative text appears opposite each photograph. The little volume will be of interest to a mother who has the desire to record the development of her child.

Medical State and National Board Summary. By William H. Kupper, M. D. Cloth. Pp. 369. Paterson, New Jersey: The Colt Press Publishers, 1942.

Examinations for licensure before State Medical Boards are not to be looked upon with disrespect. A physician, who is contemplating a State Board examination, usually finds it desirable to review many phases of medicine and surgery, in which he may have had only a casual interest. In the present volume, the author has made available most of the fundamental principles of

(Continued on Page 22)

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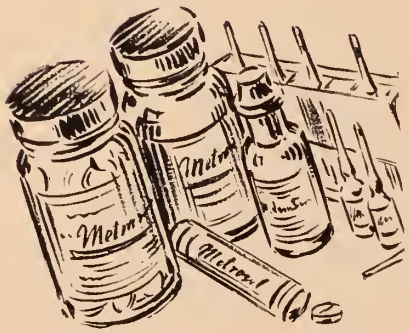
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BOOKS RECEIVED

(Continued from Page 20)

the complex science of medicine. A compact style of presentation has been made possible through illustrations and through the elimination of repetitions. A large number of questions given in previous years by the National Board of Medical Examiners are included and appropriate answers indicated.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 112)

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Army Medical Examinations of the First Draft," by Harry B. Reynolds, Major M. R. C., Medical Examiner for 91st Division, N.A.—The mustering of the first draft of the National Army [Year, 1918] is now completed, and the data is available on which may be based fair judgment of the efficiency of the machinery employed. Approximately forty-eight thousand men have been received at Camp Lewis. They have come from Montana, Wyoming, Idaho, Washington, Oregon, California, Utah, Nevada and Alaska. . . .

From an Article on "Tentative Report on Social Insurance," by Committee of Los Angeles County Medical Society, Dr. William Wenzlick, Chairman; Dr. J. Ross Moore, and Dr. T. Percival Gerson. Introductory Remarks by the Chairman.—The purpose of a Health Insurance Act is to enable a wage-worker to meet the expenses of his illness, and to compensate him to some extent for the loss of his wages, upon which he and his family depend for their sustenance. . . .

The State Social Health Insurance Committee of the

(Continued in Back Advertising Section, Page 26)



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 58 FEBRUARY, 1943 NO. 2

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) Fresno 1943
F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER JOHN HUNTON
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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

U. S. SUPREME COURT'S OPINION ON GUILT OF AMERICAN MEDICAL ASSOCIATION AND MEDICAL SOCIETY OF DISTRICT OF COLUMBIA, IN "GROUP HEALTH ASSOCIATION" CASE

An Important Opinion, For Both the Present and Future.—On January 18th, the Supreme Court of the United States handed down its unanimous opinion, that the two petitioners (American Medical Association and Medical Society of the District of Columbia) who, in a jury trial in a lower court, had been fined $2,500 and $1,500 respectively, were given a fair trial on the charge of conspiring against "Group Health Association, Inc.," of the District of Columbia, in violation of the Sherman Antitrust Act of 1890—and that the judgments should stand affirmed.

This much discussed case was started in 1937 when a grand jury, in the District of Columbia, brought in an indictment against the two organizations and certain officers thereof and individual physicians. In the initial trial, the Washington District Federal Court ruled in favor of the medical societies and members involved, but this decision was reversed by the District Court of Appeals. The jury trial and judgment for penalties then followed.

The American Medical Association and Medical Society of the District of Columbia thereupon petitioned the United States Supreme Court to not affirm the judgments previously rendered in the lower court. However, on January 18, 1943, the Supreme Court of the United States affirmed the guilt of the two medical societies.

* * *

Court's Opinion Has Broad Implications.—Concerning the opinion handed down by the Supreme Court, it can be said that it has implications more far-reaching than may be at first thought. Justice Roberts, who wrote the opinion, used language applying in its scope not only to the case before the Court, but also to similar cases such as may arise in any State in the Union; in the profession of medicine, and possibly, also, in the legal and other professions.

It is most important that organized medicine, as represented in state and component county medical societies, shall henceforth be on the alert, and avoid procedures and actions that may make them amenable to like judgments which could be entered in lower local courts, where the Supreme Court opinion would probably be cited as final

authority. Therefore, it may be worthwhile to consider briefly some aspects of this now celebrated case. The full opinion appeared in the *Journal of the American Medical Association,* January 23, 1943, on page 267, and members may find its perusal of interest.

* * *

Court's Permission to Submit An Appeal.—When the Supreme Court permitted the appeal to be listed for its consideration, it seemed that the following issues would be considered:

1. Whether the practice of medicine is a "trade" within the meaning of the Sherman Act of 1890, or whether, as a profession, it is exempt from the said Act.

2. Whether the charges made in the indictment were proved.

3. Whether the Norris-LaGuardia Act relating to antiinjunctions and the Clayton statute concerning antitrust actions, barred prosecution.

* * *

Court's Opinion after Hearing the Appeal Arguments.—In its opinion, rendered on January 18th, the Supreme Court stated, in essence, that it found:

(a) That the charges of violation of the Sherman Antitrust Act of 1890 were warranted;

(b) That a fair trial had been held;

(c) That the question, whether the practice of medicine was a profession or trade was not a matter in issue;

(d) That the labor acts (Norris-LaGuardia and Clayton statutes) did not apply in the instant case;

(e) That "Group Health Association, Inc.," which was brought into being in 1937 by "Home Owners' Loan Corporation"—an organization of some 2,500 Government employees who were in coöperation to provide medical care and hospitalization services for their members through its own staff of physicians, in return for monthly payments or dues into a common fund created for such purpose—was in fact a "membership corporation engaged in business or trade";

(f) That the American Medical Association and the Medical Society of the District of Columbia had

"induced and coerced their members to boycott Group Health Association by refusing to serve on its staff or to consult with doctors on its staff, and induced and coerced all the hospitals in the District of Columbia, not operated by the Government, to boycott Group Health Association by denying hospital privileges to doctors serving on its staff . . . ;"

(g) That the A.M.A. and its constituent unit, the Medical Society of the District of Columbia had

"combined and conspired to restrain Group Health Association in its business of providing medical care and hospitalization, to restrain the doctors on its staff, as well as other doctors, in the pursuit of their callings, and to restrain Washington hospitals in the operation of their business . . . ;"

(Editor's Note. Referring to "coercion" mentioned in the Court's opinion, it may be permissible to assume that, in part, the same referred to the procedures and supposedly prohibitive actions taken by the A.M.A. and/or the District Medical Society against any member who would be found serving on the Group Health Association staff, or consulting with its members, the penalty for such service or consultation being threat or pain of expulsion from the Medical Society of the District of Columbia; and also the steps taken to prevent staff members of Group Health Association from utilizing the facilities of hospitals located in the District of Columbia);

(h) The Court found that the A.M.A. and District Medical Society had practiced "coercion" and that the said actions did fall within the scope of the Sherman Antitrust Act of 1890,

"whether the conspiracy was aimed at a restraining or destroying competition, or had as its purpose a restraint of the free availability of medical or hospital services in the market."

It was on the above points that the Supreme Court of the United States affirmed the judgments of the lower court.

* * *

Some Deductions from the Supreme Court Opinion.—If the above comments are correct, it may be in order to emphasize how important it is that no medical society shall approve resolutions or take actions similar in nature to those which brought so much trouble and expense to the American Medical Association and the Medical Society of the District of Columbia.

As we understand it, there is nothing in the Supreme Court decision that should prevent a medical society from laying down the qualifications which must be possessed by applicants for membership, so long as they relate only to legal licensure and individual qualifications of professional or moral nature.

And, in similar degree, the governing or medical authorities of a hospital should be permitted, as heretofore, to adopt rules for staff membership and utilization of hospital facilities that have, as their purpose, not only the protection of health and lives of patients, but the good name of the institution in its own community. In other words, the institution shall have the right to approve all proper procedures that will make for the protection of patients from incompetent practitioners of medicine and surgery, or that will promote its own standards of adequate medical and hospitalization care.

* * *

Relation to County Society Disciplinary Procedures.—Another thought, in connection with what took place in relation to the District of Columbia case here receiving comment, concerns disciplinary procedures by medical organizations. It cannot be too strongly emphasized—while a medical organization like any club or other organization, has the right to set up its own qualifications for membership—that once a physician

becomes a member, he establishes rights for himself, akin almost to property rights, and his membership cannot be jeopardized or taken from him, except after fair trial, and in which all by-law procedures have been meticulously observed. In every such disciplinary case before a medical organization, it is mandatory that any penalties that may be approved, shall be handed down in full accord with by-law provisions.

And, attention may be called to the provisions in the by-laws of the California Medical Association, whereby it is mandatory upon all component county societies that the disciplinary procedures outlined in Chapter II shall be observed. County Societies which have not made the necessary revisions in their own by-laws should do so promptly.

WILL TAXATION OF CALIFORNIA'S NONPROFIT HOSPITALS IMPERIL THEIR CAPACITY FOR SERVICE?

Court Case of Seaside Hospital.—Excerpts from a case of first impression, in relation to placing nonprofit hospitals within the scope of the California Unemployment Insurance Act appeared in the January issue of CALIFORNIA AND WESTERN MEDICINE (on page 38).

The decision referred to was handed down by Judge Emmet H. Wilson of the Superior Court of the State of California in and for the County of Los Angeles, the case being one that concerns the Seaside Memorial Hospital of Long Beach, a nonprofit corporation.

However, the issues involved affect many other nonprofit hospitals now operating in California—with their possible future capacity for charitable work at stake,—and they also have relation to the interests of physicians who use the facilities of the hospitals.

Judge Wilson's opinion is in contradiction to the views held by the State bureau known as the California Unemployment Commission and, unless remedial legislation is enacted, the points laid down by him will remain in question pending appeals to the higher courts of the State. In the meantime, between fifty to one hundred nonprofit California hospitals may find themselves involved in court litigation on whether they have a tax-exempt status.

* * *

Basis of the Commission's Contention and Judge Wilson's Opinion.—The controversy seems to hinge around the claim of the California Unemployment Commission that no hospital in this State may qualify as a charitable institution unless at least fifty per cent (50 per cent) of its work is charity. As is well known, California hospitals, have not been, as a class, the recipients of heavy endowments that would permit extensive charity work; at least not to the same extent as similar institutions in older Eastern States. However, many of the California hospitals have been incorporated as nonprofit organizations, an excellent evidence of their intention to do as much charity work as their respective incomes will permit.

When the Seaside Hospital of Long Beach was notified that the California Commission was levying the tax, it secured the coöperation of the Association of California Hospitals, it being necessary to carry the court proceedings to the California Supreme Court before Superior Court Judge Wilson was permitted to place the case on his calendar for trial. As stated above, excerpts from his decision in favor of the Seaside Hospital appeared in the January issue, on page 38, and one portion thereof is so much in accord with the views held by many physicians that it is here given for readers who may have missed the item:

Petitioner's claim of exemption under section 7 (g) of the statute. . . .

In order to do charity petitioner must have funds. It is not necessary that a charitable organization originate from or be maintained by means of bequests, donations, and offerings from public moneys, nor need its representatives go on the streets with coin boxes or tambourines soliciting passers-by in order to supply its treasury. It may collect from those who are able to pay for services rendered to them and use the remaining surplus in its charitable work without loss of its status as a charitable corporation. . . . Neither a certain defined amount of its expenditures for charity nor the percentage thereof in relation to its income or to its other expenses is the criterion. Not all of the patients need be treated free of charge. The number of free beds maintained by petitioner is only relative and is not important. There is no restrictive terminology in the statute from which it can be inferred that the legislature intended that a charity must be extensive in order to qualify under the law. To tax a nonprofit hospital is to place a direct tax on the sick and injured. The stipulated facts and the applicable law demonstrate that petitioner is organized exclusively for charitable purposes, that it is operated exclusively for such purposes, that no part of its net earnings inures to the benefit of any private shareholder or individual, and that by reason of the provisions of section 7 (g) of the act it is exempt from taxation under the statute and from the jurisdiction of respondents.

The action of the California Commission is the more difficult to understand because these nonprofit hospitals have thus far been held to be exempt under the Federal Income Tax and the Federal Social Security Act. A change in California status might lay the foundation for Federal taxation of them in the future and still further endanger their capacity for service.

* * *

Proposed Remedial Legislation.—To clarify the situation, a referendum measure has been submitted to the California Legislature now in session, and in due time will be placed before the voters for decision. It will be known as Assembly Constitutional Amendment No. 17, and was sponsored by 70 Assemblymen! Also, an amendment to the California Unemployment Insurance Act was introduced at Sacramento, and if it receives the approval of the Legislature and Governor, it should bring about a betterment in the situation

that has arisen through the Commission's rulings. The proposed amendment follows (portion to be amended is in italics):

PROPOSED AMENDMENT OF SECTION 7 (G) OF THE CALIFORNIA UNEMPLOYMENT ACT

(g) Service performed in the employ of a corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children, or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, *including a nonprofit corporation or association, the articles of incorporation or association or by-laws of which forbid the distribution of any of its funds, revenues or other assets to any of its members as dividends or upon dissolution or otherwise, and which is not availed of for any such purpose, and which owns and operates a hospital, the facilities and services of which are available to the general public, and all of whose funds and revenues are devoted exclusively to the operating expenses, retirement of indebtedness and the improvement of such hospital or to other benevolent or charitable purposes.*

In the meantime, physicians who are staff members of nonprofit hospitals may desire to contact their administrative boards, in order to remain in better touch with the problem.

* * *

An Analagous Issue in New York.—Of collateral interest in connection with the above is a news item noticed on the day of this writing, from which the following excerpt is taken. (For complete text, see in this issue, on page 95):

"Like countless other charitable, educational and religious institutions in America, this hospital (New York Infirmary for Women and Children) probably would never have been created or maintained in a country which had limited opportunity in individual money making efforts.

"The board unanimously agreed that institutions like the Infirmary may be permanently crippled if contributions were withdrawn by individuals affected by the new ruling."

Perusal of the above statement raises the query —Is it not, perhaps, a short-sighted policy to institute governmental measures which, when carried through, result in stifling donations that otherwise might be made for the betterment of the public welfare and health; or which, through burdensome taxation, prevent nonprofit institutions from maintaining or extending their charitable work in behalf of many citizens in need thereof?

ON VARIOUS TOPICS

Charles B. Pinkham, M. D. Retires as Secretary of the Board of Medical Examiners of the State of California.—A large number of the physicians now practicing in California have met Doctor Charles B. Pinkham, since January, 1913, a member of the Board of Medical Examiners of the State of California, and who also acted as its secretary from that date—his service in this capacity covering a period of some thirty years. Doctor Pinkham's record is notable, not only because of its long, continuous term, but also because of the conscientious and able manner in which he has carried on this important work during the last three decades.

Many members of the profession do not appreciate the onerous nature of the duties and responsibilities which fall to the lot of colleagues who are willing to take over the obligations which go with membership on a State Board of Medical Examiners. Of special importance to a properly functioning Board is the physician who acts as its executive officer. It is he who is constantly called upon to safeguard the interests of medical standards, and to counter the endeavors and onslaughts of those who would seek licensure to practice without fulfilling to the last degree, the requirements laid down in the Medical Practice Act. It is to the great credit of Doctor Pinkham, who has submitted his resignation to Governor Warren—because he has now reached the retirement age—that succeeding Boards of Examiners have been unanimous in their praise of the important investigative and other work which he has graciously and efficiently carried on.

Doctor Pinkham received his A. B. degree from Stanford University, and his M. D. in New York. He was registered in California in 1900, succeeding to his father's medical practice in Sacramento in 1901. It has been his privilege to serve under Governors Hiram Johnson, William D. Stephens, Friend W. Richardson, C. C. Young, James Rolph, Jr., Frank Merriam, Culbert L. Olson, and Earl Warren.

During these thirty years, Doctor Pinkham has been instrumental in taking the lead in many efforts to maintain medical standards. Particularly may be mentioned his endeavors in relation to elimination of quack specialists for men; diploma-mill activities; fraudulent medical licenses issued by some of the State Medical Examining Boards and the endeavors of the holders thereof to secure California medical licenses; eradication of the Pacific Coast Abortion Ring; extirpation, with the assistance of Postal Inspectors of a nation-wide ring of eyesight swindlers; and coöperation with the Federal and State authorities in suppression of narcotic irregularities.

As Doctor Pinkham retires for well-earned rest, he has the good wishes of members of the California Medical Association; who also hope that a successor, equally well qualified, may be found to take over his duties.

Amendments to Medical Practice Act of California.—Editorial and other comment on proposed amendments to the medical practice acts of many States of the Union was given in the January issue of CALIFORNIA AND WESTERN MEDICINE (pages 2 and 36), and in the current issue appears a copy of a letter addressed to the American Federation of State Medical Boards by the Oklahoma Board of Medical Examiners (page 80). A perusal of the queries in last month's JOURNAL, and the Oklahoma letter, should be

sufficient to indicate that the proposal for widespread amendments to medical practice acts is neither simple nor devoid of danger to medical standards.

For the information of members of the California Medical Association, it may be stated that the members of the C.M.A. Council gave the subject of amendments to the State's Medical Practice Act careful consideration. The conclusion was reached that certain simple amendments, suggested by the Board of Medical Examiners would make it possible for that Board to meet any emergencies that might arise. The proposed amendments will make for simpler procedures in giving examinations, which also may be more frequently held. It is believed these will answer medical service needs, and without endangering California's established standards.

California's 55th Legislature in Recess during February: Proposed Legislation.—This year, under existing war conditions, even the California Legislature is holding what may be called a modified, streamlined gathering. The 55th session convened on Monday, January 4th and by the constitution could remain in session for not exceeding thirty days; then to recess for not more than thirty days. The Legislature is booked to reconvene on Monday, March 8th.

At this writing, it is not possible to present to readers a complete list of all proposed legislation having direct or indirect relationship to public health and medical matters and standards. A partial list appears in this issue on page 79. The committees on public policy and legislation of the county medical societies should scan the above lists and also any others that may be sent.

In the January number, on pages 35 and 36, the rosters of the two legislative houses were printed, the home addresses of State Senators and Assemblymen being given. It may be desirable to preserve the lists for future use and reference. (A summary on legislation of medical interest, presented to the U. S. Congress in the year 1942, appears on page 74 of this number of CALIFORNIA AND WESTERN MEDICINE.)

It is too early to state with positiveness what struggles may come to the front on legislation in which medicine and the associated professions have natural interests. When the 55th Legislature again convenes on March 8th, the legislators will take up in earnest the consideration of proposed laws. Fortunately, the medical profession does not have before it, a menace such as confronted it some four years ago, when the then Governor espoused a Compulsory Health Act as an item of "must legislation," that was to be enacted forthwith, willy nilly. For the defeat of that project, physicians of California may continue to render thanks.

In due course, bulletins will be sent to the component county societies, informing them concerning the more pertinent matters, and indicating procedures on appropriate lines of desirable action. In the meantime it will be wise procedure if county societies, their officers and committees, and also members, refrain from giving endorsements to proposed legislation, except as such may be requested by the C.M.A. Committee on Public Policy and Legislation of which Doctor Dwight Murray of Napa, is chairman. This in accord with past action of the C.M.A. House of Delegates. (For Committee roster, see adv. page 2.)

EDITORIAL COMMENT†

OSTEOPATHIC AND CHIROPRACTIC IMMUNOLOGY

Experimental evidence of the nonexistence of the alleged "immunity center" in the brain, the theoretical basis of much of osteopathic and chiropractic therapy, is currently reported by Stanton[1] and his coworkers of the New York State Psychiatric Institute.

The first serious suggestion of a neurological integration of specific immunity came from a study of the effects of certain drugs on serum titer. Some of these drugs were known or assumed to act primarily on the central or peripheral nervous system. Both increases and decreases of specific antibody production were reported, sufficient to make plausible the existence of a specific "immunity center" in the brain.

Metalnikov,[2] and Diacono,[3] and others attempted to confirm this plausibility by a study of immunologic conditioned reflexes. Animals were given an electric shock or other conditioning stimulus immediately before injection of heat-killed bacterial vaccines or alien erythrocytes. After numerous repetitions of this association, the rabbits showed a significant rise in homologous antibody titer on application of the conditioning stimulus alone. Few if any controls were tested. Using a large number of animals with adequate controls, Kopeloff[4] and his colleagues were unable to confirm these findings. In their hands fluctuations in agglutinin nitrogen were almost identical in conditioned and normal control animals.

Other investigators attempted to confirm the neurogenic origin of specific antibodies by "antigen depot" experiments. Schamburow,[5] for example, injected nonviable typhoid vaccine into the anterior chamber of the rabbit eye. He found the specific agglutinin titer of the aqueous humor of the injected eye increased to 8-fold that of the synchronous agglutinin titer of the blood stream. This he accepted as proof of a local synthesis of specific agglutinins in the injected eye. Studying the opposite, nonvaccinated eye, he often found

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

an agglutinin titer 2 to 3 times that of the blood stream, conclusive evidence from his point of view of a reflex local synthesis of specific typhoid agglutinins in the nonvaccinated eye. This he believed could only be brought about through a specific "immunity center" in the brain. The experimental data for this conclusion, however, could not be confirmed by Madison[6] and other American investigators.

In contrast with these contradictory results, experiments involving destruction of certain parts of the nervous system have given consistent data. Metalnikov,[4] for example, found that specific anticholera immunity could be produced in certain caterpillars by the injection of heat-killed cholera vaccine. Destruction of the third thoracic ganglion in these caterpillars, however, prevented the development of this specific immunity, destruction of other ganglia having little or no inhibiting effect. Bogendörfer[7] sectioned the spinal cord of dogs usually at the 6th cervical vertebra, control animals being sectioned in the lower thoracic region. All control (low spinal section) animals produced specific agglutinins on injection with bacterial vaccines. Practically no agglutinins were formed by the high-level (cervical) spinal-section dogs. This clearly suggested to him the existence of a neurogenic immunity center, interrupted by high-level spinal cord section.

Stanton and his coworkers attempted to confirm this high-level immunologic paralysis, using white rats as the experimental animals. Rats were selected because of negligible mortality with adequate postoperative care. Groups of from 10 to 20 rats were sectioned between the 1st and 2nd thoracic vertebrae. An equal number of "operated controls" were sectioned between the 6th and 10th thoracic vertebrae. The animals were placed in a warm-box until recovery from the operation. Five to 14 days after recovery both groups, together with an equal number of "nonoperated controls," were given an intraabdominal or intravenous injection of a standard dose of washed sheep erythrocytes. The animals were bled 7 days later, and the antisheep hemolytic titer of each animal estimated with the aid of guinea-pig complement. In a typical experiment, 23 out of a group of 28 nonoperated controls yielded serums with amboceptor titers often as high as 1:2560. Ten of the 13 low-level "operated controls" yielded antiserums with a maximum titer of 1:1280. Among the 19 animals with high thoracic cord section, 15 produced no demonstrable hemolysin. The remaining four gave traces of hemolysin (average titer 1:60). A similar almost complete suppression of specific antibody formation was recorded for all other high-level operated groups, seeming confirmation of the neurogenic theory of specific immunity.

Stanton and his colleagues, however, took cognizance of the fact that the observed "immunologic paralysis" is not the only effect of high-level spinal cord section. The high-level operated animals also lost their normal temperature control. Maintained at ordinary room temperature, their rectal temperatures often fell from the average normal of 34.5 C to 27 C or even lower. Before the existence of a specific "immunologic paralysis" could be deduced from their data, therefore, the possible deleterious effects of this subnormal body-temperature must be ruled out. To do this, parallel groups of high-level spinal cord sectioned rats were maintained at higher external temperatures. At 33 C external temperature the animals showed practically no fall in normal rectal temperature. In these animals antibody production was equal to that of the unoperated controls. This is conclusive evidence that high-level cord section in itself has no deleterious effect on specific antibody synthesis, the observed suppression of immunologic function being a secondary effect of subnormal body-temperature.

Fifty years ago, before the development of modern theories of humoral immunity, Sawtschenko[8] made a similar observation. He found that when the cervical cord was sectioned in pigeons, the birds lost their natural immunity to anthrax. This he attributed to their lowered body-temperature, avian resistance to anthrax then being attributed solely to their high normal body-temperature.

The alleged totalitarian "immunity center" in the brain initiating and coördinating specific antibody production has been of philosophic interest among European investigators largely on account of its political implications.[9] American clinicians, however, will probably find their main interest in its application to certain unofficial methods of clinical therapy. Hulburt,[10] of the American Osteopathic Association, for example, states that it is a basic tenet of osteopathic therapy that interference with spinal function causes "a resulting intemperance with the body's ability to make its own serum and antitoxins to fight infectious disease processes." This theory is endorsed in somewhat more picturesque language by Chiropractors,[11] who allege that as a result of spinal cord injury "the efferent nerves are prevented from transmitting to the various bodily organs the mental impulses necessary for their proper function (e.g., specific antibody production)." Disproof of the neurogenic theory of specific antibody production is, therefore, equivalent to disproof of one of the major basic tenets of both Osteopathy and Chiropractic.

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DIANTIGENIC INSULIN

An apparent confirmation of the newer theories of specific antibody production is seen in the clinical evidence of the existence of two distinct antibodies against crystalline insulin, recently reported by Lowell[1] of the Massachusetts Memorial Hospital.

The earlier immunologists assumed a one-to-one relationship between specific antigen and antibody, all observed allergic or immune phenomena being explained on this basis. The possibility that a single antigen may give rise to two or more different antibodies, however, would follow logically from the more recent template theory of specific antibody synthesis. According to this theory[2] specific antibodies are new-formed protein molecules synthesized intracellularly as "templates" of the injected antigen. Assuming that the antigen is asymmetrical in chemical structure, two or more different templates might be formed to fit its different poles. Moreover, homologous templates formed by different histological units might well be of different structure or function.

One of the best illustrations of the template theory is the recent demonstration by Smadel[3] and his coworkers of the Rockefeller Institute of the dual antigenicity of vaccine elementary bodies. Earlier investigators demonstrated the existence of two different soluble antigens in vaccine lymph,[4] a heat-labile (L) antigenic molecule, readily destroyed by heating to 56° C, and a heat-stable (S) molecule resisting heat to 95° C. There was suggestive evidence that in the elementary bodies the two antigens may be conjugated to form a single protein complex, a duplex LS-antigen capable of reacting equally well with anti-L and anti-S serum. The Rockefeller Institute biochemists isolated this hypothetical LS-complex from dermal pulp of cutaneously infected rabbits, and showed that it is a homogeneous protein of approximately the same molecular size as serum globulin. This protein is precipitated quantitatively with either anti-L or anti-S precipitin. They found that the L-pole of this native antigen can be partially (L') or completely (L") denatured by heat, without demonstrable alteration of the S-pole. By means of enzymic digestion the S-pole can be similarly degraded (S', S") without demonstrable injury to the L-pole. Dissociation of the LS-molecule into free L- and S-proteins, however, was not demonstrated.

The existence of diantigenic proteins affords a convenient explanation of numerous puzzling clinical phenomena. In 1929, for example, Cook and Spain[5] pointed out the lack of correlation between the skin-sensitizing and smooth-muscle sensitizing antibodies formed against the same alien protein. Somewhat later Loveless[6] demonstrated the existence of two antibodies against the same pollens. One of these was a thermostable, nonsensitizing antibody capable of binding pollen-protein, the other a thermolabile, sensitizing antibody presumably responsible for the observed allergic phenomena. Since ragweed pollen is known to be a complex protein mixture, no definite conclusion could be drawn from the observed apparent diantigenicity.

A year ago Yasuna,[7] of the Boston City Hospital, found 11 recorded cases of general sensitivity to crystalline insulin, adequately confirmed by allergy studies. A twelfth case was reported from his Diabetic Clinic, in which severe insulin allergy was associated with marked insulin tolerance. Mouse-test showed that 0.5 c.c. of the patient's serum would neutralize twice the convulsive dose of crystalline insulin. The neutralizing properties were not destroyed by heating the serum to 57° C for 2 hours. A 1:32 dilution of the same serum would passively sensitize normal human skin to crystalline insulin. The skin-sensitizing activity, however, was completely destroyed by heating the serum to 57° C for 2 hours. Lowell concludes from these and other data that "there were two antibodies in the patient's serum, an allergic antibody which is heat-labile and confers sensitivity on normal skin, and an insulin-neutralizing antibody which is heat-stable and was capable of destroying the physiological effects of crystalline insulin."

Insofar as crystalline insulin is a single protein molecule, it would seem logical to conclude that insulin protein is diantigenic, capable of stimulating the production of two functionally distinct antibodies. Insulin would thus be the latest addition to the rapidly increasing list of multiantigenic proteins of theoretical and practical interest. Other explanations of the dual antibodies (anti-insulins) are of course possible.

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ORIGINAL ARTICLES

Scientific and General

SULFATHIAZOLE REACTIONS IN TOXIC AND NONTOXIC INDIVIDUALS*

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SINCE sulfathiazole has been so effective in the treatment of various infectious conditions at the Station Hospital, Camp Haan, California, its undesirable side effects have become of increasing interest and importance to us. We had observed that these side effects seemed to occur most frequently in patients who were toxic and febrile from their illness and were apparently less common in the individual whose disease did not cause a toxic, febrile response, irrespective of the total sulfathiazole dosage or its length of administration.

In an effort to substantiate or disprove this observation, hospital records of the last 300 patients to receive a single course of sulfathiazole on all services at this hospital were reviewed. Cases where two or more courses of sulfathiazole had been administered with intervening intervals were purposely excluded from this series. Numerous such cases were encountered but were omitted due to our interest in the recent work of Lyons and Balberor,[1] and others.[2] We propose to report the incidence and our conception of the mechanism of sulfathiazole side effects in these cases at a later date.

These 300 cases differ somewhat from others previously reported[3] in that all patients were men, predominantly young and vigorous. The age range was from 18 to 52 years, with a mean of 25.1 years. It was found in these cases that side effects attributable to sulfathiazole occurred approximately five times more often in toxic, febrile individuals than in the atoxic, afebrile, with due consideration also being given to total drug dosage and its length of administration.

Sulfathiazole blood levels will not be cited in any of the cases here reported since no excessive concentrations were encountered and it seems generally accepted[4] that blood concentration is not important in the production of sulfathiazole side effects.

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COMPARISON OF "TOXIC" AND "ATOXIC" CASES

Upon segregating these cases into so-called "toxic" and "atoxic" groups, we were agreeably surprised to find them almost equal in number and that there was no appreciable difference in the average age, the "toxic" being 25 and the "atoxic" 25.2 years. There were 149 toxic, febrile individuals and 151 who had had no fever or appreciable toxic response to their disease, either immediately preceding or throughout their hospital stay. All of the so-called "toxic" cases exhibited some form of acute inflammation, and since MacCallum[5] states that probably every inflammation is accompanied by some general disturbance, such as fever, the presence of an appreciable degree and extent of fever was taken as an index of toxicity existing from the disease present. Cases were therefore arbitrarily placed in a group called "toxic" when fever from the disease of 100° F. or more persisting for two or more days, or of 99.6° F. persisting for four or more days had been experienced. All others were placed in a second group called "atoxic," although we are aware that toxicity may exist without the presence of fever.

Table 1 shows the composition of these two groups, with conditions causing hospitalization and sulfathiazole administration. This study was attempted to identify persons showing evidence of drug intoxication, no thought being given to the existence of proper indications for its administration.

Thirty patients (10 per cent) experienced undesirable reactions from the sulfathiazole, three each exhibiting two different side effects. No deaths attributable to the drug occurred among the entire 300 cases. Table 2 summarizes these side effects as to type and the group in which they occurred.

It is thus apparent that 83 per cent of those patients experiencing undesirable effects were in the so-called "toxic" group, while but 17 per cent were in the so-called "atoxic" group; or expressed in a different manner, 17.4 per cent of the 149 "toxic" patients showed evidence of drug intolerance, while but 3.3 per cent of the 151 "atoxic" exhibited similar effects. Before these figures might be assumed to be significant, it was felt that drug dosage and length of its administration should be compared in the two groups; and upon such comparison it was found that the average "toxic" patient had received 20.5 gm. of sulfathiazole over an average period of 4.9 days. The lowest total dosage was 5 gm. and the highest 71 gm. The shortest time of administration was one day, and the longest 16 days. On the other hand, the average "atoxic" individual had received 25.3 gm. of sulfathiazole over an average period of 7.3 days; the smallest total dose being 5 gm. and the greatest being 101 gm. The shortest period of administration was two days and the longest 35 days.

Thus the average "toxic" patient received 25 per cent less sulfathiazole over a 33⅓ per cent

shorter period of time than did the "atoxic" patient, yet developed five times as many undesirable effects from its use.

ANALYSIS OF PATIENTS EXHIBITING SIDE EFFECTS

This discussion might now have some significance in its relation to the side effects observed in all thirty patients, but definite conclusions cannot be reached without further analysis.

the production of its side effects. We believe that other factors besides dosage and length of administration play a part in their causation. Hendricks[4] appears to confirm this view by his statement that the number and severity of the anemias occurring among his patients given sulfonamide compounds were not dependent upon the total dosage received, the duration of treatment or the blood concentration.

TABLE 1.—*Condition Causing Hospitalization and Sulfathiazole Administration, Placed in "Toxic" or "Atoxic" Groups*

"TOXIC GROUP"*		"ATOXIC GROUP"*	
Upper respiratory infections, acute	34 cases	Gonorrhea	45 cases
Postoperative abdominal	23 cases	Abscess, minor, localized	25 cases
Lobar pneumonia	21 cases	Sinusitis, chronic	15 cases
Bronchitis, acute	20 cases	Otitis media, chronic	15 cases
Broncho-pneumonia	17 cases	Urethritis, nonspecific	13 cases
Cellulitis	9 cases	Prostatitis, chronic	6 cases
Postoperative compound fractures and other operative orthopedic conditions	7 cases	Cystitis, chronic	4 cases
Prostatitis, acute	4 cases	Postoperative compound fractures and other orthopedic cases, operative	4 cases
Epididymitis, acute	4 cases	Balanitis	3 cases
Sinusitis, acute	4 cases	Pustular dermatoses	3 cases
Otitis media, acute	3 cases	Postoperative abdominal	3 cases
Lymphangitis, acute	2 cases	Chancroid	1 case
Infectious mononucleosis	1 case	Entero-colitis	1 case
Encephalitis	1 case	Miscellaneous, used prophylactically, gun-shot wounds, multiple abrasions, lacerations	11 cases
Peri-nephritic abscess	1 case		
Totals	151 cases	Totals	149 cases

* Explanation of terms "Toxic" and "Atoxic" appears in text.

Among these thirty patients, sixteen exhibited side effects sufficiently severe to cause drug discontinuance. These cases are summarized in Table 3, which shows that thirteen (73 per cent) were included in the "toxic" group with but three (27 per cent) being classified as "atoxic." This finding would seem to be not at all inconsistent with the 83 per cent incidence in the otherwise toxic and the 17 per cent incidence in the nontoxic individual as was found in the entire thirty patients experiencing any degree of side effect.

Table 3 also shows that the thirteen "toxic" individuals received sulfathiazole for an average of 5.1 days, as against 9 days for the three "atoxic" patients. Total average dosages for the thirteen "toxic" people was 20.3 gm., as contrasted with an average of 30 gm. for the "atoxic." Again we feel that these calculations are not dissimilar from those found in the entire thirty patients exhibiting side effects.

It is true that Table 3 reveals an average daily dosage of 3.9 gm. of sulfathiazole for the thirteen "toxic" people as against 3.3 gm. for the "atoxic," but it is felt that this difference of less than 1 gm. in the average total daily dosage could hardly account for an incidence of sulfathiazole side effects several times greater in the "toxic" than in the "atoxic" person, particularly since in these sixteen patients the "atoxic" received sulfathiazole on an average of almost four days (80 per cent) longer than did the "toxic." This seems especially pertinent since numerous observers[6] have stated from experimental and clinical observations that prolonged administration of sulfathiazole seems to be a most important factor in

Excessive vomiting seems to occur most frequently early in the course of sulfathiazole administration, and in the cases here cited, this happened in all but one instance. The exception was Case 1 in Table 3. If all early cases of excessive vomiting are excluded from the sixteen cases under discussion, there remain eleven patients, eight in the "toxic" and three in the "atoxic" groups, with a resultant incidence of almost three times the side effects in the "toxic" as in the "atoxic" people. We can find no possible standpoint, but that the incidence of sulfathiazole side effects is much greater in the "toxic" than in the "atoxic" individual. In fact, if we were to eliminate all so-called "atoxic" cases from our series we would be left with 149 "toxic" individuals with an incidence of 25 patients (16.55 per cent) showing undesirable drug effects, a figure very close to that of Pepper and Ham[3] whose entire series we would classify as "toxic."

DISCUSSION

Clinical findings have been presented from 300 patients given sulfathiazole, in support of a premise that undesirable drug side effects occur more frequently in patients obviously toxic and febrile from their illness, than in those individuals whose disease is unaccompanied by such systemic effects. A review of available literature reveals certain evidence tending to support this contention.

The incidence of sulfathiazole intoxication has been recorded in several series of cases, such as those of Fletcher, Gibson, and Sulkin[3] and Culp,[3] who have reported in the first instance,

women, and in the second, men, treated for gonorrhea, with sulfathiazole. The incidence of drug side effects was 6.7 and 6.9 per cent respectively in those two series. It seems reasonably safe to assume that the majority of the cases in both of these series represented people we would classify as "atoxic." In contrast, others have recorded an

TABLE 2.—*Type of Side Effects and Group in Which They Occurred*

	"Toxic"	*"Atoxic"*	*Total*
Nausea and vomiting	18	2	20
Fever from drug...	2	3	5
Dermatitis	1	0	1
Dermatitis and drug fever	1	0	1
Agranulocytosis ...	1	0	1
Conjunctivitis, and nausea and vomiting	1	0	1
Cyanosis, and nausea and vomiting	1	0	1
Deaths	0	0	0
Totals	25 (8.35%)*	5 (1.65%)*	30 (10%)†

* Percentages represent incidence in entire 300 cases. Expressed as the incidence among those showing sulfathiazole intoxication they would be 83.5% and 16.5% respectively.

† This table shows thirty patients experiencing a total of thirty-three side effects, two each occurring in three different "toxic" patients.

incidence of sulfathiazole reaction in groups of cases composed of patients, all or for the most part, of a type classified by us as "toxic." Among these writers are Carrol, Kappel, and Lewis[3] who found a 15 per cent incidence of side effects; Reinhold, Flippin and Schwartz[3] who reported 15.6 per cent occurrences; Volini, Levitt and O'Neil,[3] who recorded 11 per cent; and Pepper and Ham[3] who gave a figure of 18 per cent, and others.[3] Comparison between the findings of the first two and the last six observers would seem to show a higher incidence of sulfathiazole side effects in the person already toxic from his disease.

The recent interesting and instructive presentations of Lederer and Rosenblatt,[7] and Merkel and Crawford[8] also deserve comment. Each of these reports cite four deaths apparently attributable to sulfathiazole medication. It was of interest to note that three of the deaths (75 per cent) in the first report occurred in people we would classify as "toxic," while all four patients in the second were apparently toxic from disease although not all were febrile.

If there be any basis of fact for the contention we advance, a reason should be forthcoming. We believe such a reason exists, at least to some extent, in the presence of two factors, in one instance, contributing to the total toxicity of the patient; i.e., drug plus disease toxicity; while in the other but one factor would seem important; i.e., the drug toxicity alone.

To quote MacCallum,[5] further, "when injury is intense enough, poison may be absorbed from the injurious agent or even from dead tissue to affect the nervous system and other organs, and to cause disturbance of their functions and what we know as illness. Even the fever itself may bring along with it disturbances in function." It therefore seems reasonable to say that those patients we have classified as "toxic" had some disturbances in the functions of various organs including the liver and kidneys.

Many observers[9] have pointed out that sulfathiazole is a drug which can and does cause more or less damage in both experimental animals and man, to various organs, including the liver and kidneys; while others[10] have emphasized the importance of proper kidney function during the course of sulfathiazole administration. Reinhold and his coworkers[3] have established that orally administered sulfathiazole in man is excreted up to 93 per cent by the kidneys, a finding supported by the work of Carrol, Kappel and Lewis;[3] while

TABLE 3.—*Patients Exhibiting Severe Sulfathiazole Side Effects, Necessitating Drug Discontinuance*

No. Diagnosis	*Days Drug* Administered*	*Grams of Drug†*	*Reaction Experienced*	*Group*
1. Epididymitis	7	17 gm.	Excessive nausea and vomiting 7th day	"Toxic"
2. Lobar Pneumonia	3	16 gm.	Cyanosis and excessive nausea, vomiting	"Toxic"
3. Lymphadenitis	8	16 gm.	Fever from drug	"Toxic"
4. U.R.I.	2	10 gm.	Excessive nausea and vomiting, early	"Toxic"
5. U.R.I.	2	4 gm.	Excessive nausea and vomiting, early	"Toxic"
6. Broncho-pneumonia	4	22 gm.	Agranulocytosis	"Toxic"
7. U.R.I.	4	15 gm.	Conjunctivitis, nausea and vomiting	"Toxic"
8. Broncho-pneumonia	3	14 gm.	Excessive nausea and vomiting, early	"Toxic"
9. Broncho-pneumonia	10	39 gm.	Dermatitis, and fever from drug	"Toxic"
10. Encephalitis	2	9 gm.	Excessive nausea and vomiting, early	"Toxic"
11. Lobar Pneumonia	12	56 gm.	Fever from drug	"Toxic"
12. P.O. Abdominal	2	9 gm.	Excessive nausea and vomiting, early	"Toxic"
13. Broncho-pneumonia	7	37 gm.	Dermatitis	"Toxic"
14. Localized abscess	9	32 gm.	Fever from drug	"Atoxic"
15. Otitis media, Chr.	10	38 gm.	Fever from drug	"Atoxic"
16. P.O. Orthopedic	8	20 gm.	Fever from drug	"Atoxic"

* Average length of administration: "Toxic" 5.1 days; "Atoxic" 9 days.

† Average total sulfathiazole dosage: "Toxic" 20.3 gm.; "Atoxic" 30 gm.
Average daily sulfathiazole dosage calculated from above: "Toxic" 3.9 gm.; "Atoxic" 3.3 gm.

It is felt that the evident variance in sulfathiazole side effects reported in previously published articles could be explained, at least in part, by the lack of division into "toxic" and "atoxic" cases. in these same reports the first workers state that transitory depression of kidney function occurs in nearly all patients receiving sulfathiazole, and the second express a belief that fear of accumu-

lation of the drug to dangerous levels is negligible except in those cases showing kidney deficiency, and yet it would appear from the work of Reinhold, et al,[3] that the drug itself contributes, at least to some slight extent, to such deficiency. It thus seems that a vicious cycle affecting kidney function may be established. Fortunately, demonstrable kidney damage was not prominent in our 300 cases, although sulfathiazole crystalluria was demonstrated in 32 per cent of them.

Two years ago, Long, et al[11] stated a belief that kidney disturbances following sulfapyridine or sulfathiazole administration might be due to either a true toxic injury to the tubules of the kidney, probably similar to that seen in mercury bichloride poisoning, or it may be due to the deposition of acetylsulfapyridine or acetylsulfathiazole crystals in the kidney tubules, and on occasion to the blocking of the renal pelves and ureters by calculi composed of acetylsulfapyridine or acetylsulfathiazole.

It now seems apparent that most, if not all, kidney damage from sulfathiazole may be due to crystal deposition in that organ. We are aware of apparently important work now in progress by Sobin,[12] which tends to confirm this view.

Reduction of renal function by both the disease and the drug may conceivably decrease excretion of the drug and thus contribute an additional factor which could contribute to the greater incidence of intoxication in febrile patients.

As a part of this same combination, Martin, and his coworkers,[13] have recently shown that the liver is important in the detoxification of sulfonamide compounds and have presented considerable work in attempting to find a means to assist in the detoxification of those drugs. Considerable evidence[14] is at hand to show that sulfathiazole may have a deleterious effect on that organ resulting in impaired liver function and possible reduction in its detoxicating ability.

No mention has been made in this discussion of side effects occurring from other sulfonamides, since our experience has been restricted almost entirely to sulfathiazole. However, it seems reasonable to assume that other similar drugs might be capable of producing the same phenomena.

SUMMARY AND CONCLUSIONS

The incidence of sulfathiazole side effects in 300 otherwise, young, vigorous soldiers has been cited.

These patients have been divided into a toxic, febrile group, called "toxic," by us for descriptive purposes, and into a second group, nontoxic from their disease, called by us, "atoxic."

The distribution of patients in each group was almost equal in number, with no difference in the average age.

The total incidence of sulfathiazole intoxication in the 300 cases was 10 per cent. There were no deaths attributable to the drug.

Sulfathiazole side effects occurred five times more frequently in the "toxic" group than in the "atoxic," or an incidence of 8.35 per cent for the "toxic," and but 1.65 per cent for the "atoxic."

The hypothesis has been advanced that the combination of effects from disease and drug, affecting sulfathiazole elimination and detoxication can account for the larger number of drug reactions found among the "toxic" patients.

Gross kidney involvement in this series of cases was not evident. No reasons can be advanced for this occurrence, except for excellent nursing care given, and the administration of sufficient fluids during drug therapy.

The occurrence of sulfathiazole side effects reported in other series of cases differ widely. It is suggested that this considerable variance might not exist to such a great extent had previous series been reported as, or had they been divided into "toxic" and "atoxic" cases.

Since we have shown clinically that sulfathiazole intoxication occurs as much as five times more often in the toxic, febrile as in the nontoxic patient, this fact should be kept in mind during the administration of all sulfonamides. This is not to be construed in any sense as an argument against the use of any sulfonamide therapeutically indicated.

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PNEUMOMEDIASTINUM AND SUBCUTANEOUS EMPHYSEMA

FOLLOWING THORACO CERVICAL TRAUMA. RECOVERY FOLLOWING CONSERVATIVE TREATMENT

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PNEUMOMEDIASTINUM is a relatively rare condition. It usually follows upon direct blows to the anterior neck and chest, resulting from rupture of the respiratory tree anywhere along its course from the beginning of the trachea, at the inferior border of the cricoid cartilage, to the alveoli themselves, with the establishment of a communication between the air passages and the anterior mediastinum.

World conditions, being what they are, offer the opportunity for the more frequent occurrence of trauma to the neck and chest. The management of cases in which pneumomediastinum is a complication of such injuries will no doubt become more standardized as more cases make their appearance and are studied carefully.

The condition is frequently associated with a tension pneumothorax, in which association the mechanism of production is tearing of the mediastinal reflection of the pleura with escape of air from the pleural space into the mediastinum. In injuries where there results a communication between the trachea or large bronchi and the mediastinum, the mechanism of production is usually by suction of air into the mediastinum by movements of the thorax, as described by Heuer[1] and observed by him in experimental work on dogs. In cases where the lung itself is injured with rupture of the alveoli, air may be forced along the peribronchial and perivascular tissues to the mediastinum, as described by Elki.[2]

But, regardless of the mechanism of production, or location of the comminucation between the air passages and mediastinum, enough positive pressure may accumulate within the mediastinum to compress the vital structures contained therein, so as to greatly embarrass circulation and/or respiration with resultant grave sequelae.



Fig. A.—Photograph showing appearance of patient on October 4, 1942, approximately 36 hours following injury.



Fig. B.—Photograph showing appearance of patient on October 14, 1942, 2 days prior to discharge.

REPORT OF CASE

A 23-year-old adult, white, male, was admitted to the Station Hospital, Fort Ord, California, via stretcher, at 11:50 P.M., October 2, 1942. He presented a severe laceration of the skin of the left chin. There were no other complaints on admission, with no evidence of shock. His past history was essentially negative. His mother had died of tuberculosis in his childhood.

One hour prior to admission he had been in an automobile accident. While riding as a passenger in the front

seat, the car struck another car, throwing the patient headfirst against the dashboard and windshield. He vomited several times after the accident, while lying in the ambulance.

On admission he was not complaining of any pain in chest or neck, and clinically presented only a lacerated chin. He was taken to surgery where the wound was débrided and sutured. Immediately after the soldier was taken off the operating table he began having some dyspnea, with expectoration of blood, and stertorous breathing was noted. Examination revealed a few râles in the right base—no dullness. There was no noticeable swelling of the neck. At this time it was felt he might be developing an aspiration pneumonia. X-ray of the chest taken at this time revealed no definite pneumonia or foreign body in either lung. Nevertheless, at 2:40 A.M., October 3, 1942, he was given the first dose of 2 grams of sulfathiazole, which was continued, grams one, q.4 hours. During the night he was dyspneic, with mild expectoration of bloody sputum, not frothy. There was still no complaint of chest pain.

By morning, October 3, 1942, a definite swelling and emphysema of the soft tissues of the neck were noted clinically. Respirations were 36, pulse 112, and he began complaining of pain in midanterior chest, with severe tenderness over the larynx on slight pressure. There were small areas of ecchymosis of the skin of the neck anteriorly over the central and left portions, and also over the right forehead. During the day the swelling of the neck increased slowly:—respirations remained 36 to 40 per minute, temperature 100, rectally, pulse 120, B.P. 127/78, W.B.C. 17,000 with 65 polymorphonuclears and 35 lymphocytes. X-ray of the chest revealed emphysema of the neck and mediastinum. Fig. 1. No pneumothorax was noted. There was no evidence of fracture of the ribs.

Sulfathiazole was discontinued and sulfadiazine, grams one, q.4 hours, was begun. The patient was placed in an oxygen tent in Fowler's position, in an attempt to reduce the emphysema and dyspnea. There was no cyanosis at any time.

On the following day, October 4, 1942, there was a marked increase in the swelling of the neck, the emphysema extending to the face and upper chest, with skin crepitation to the fifth interspace anteriorly and to the cheeks of the face. Posteriorly, the crepitation was limited to the border of the trapezius muscle on both sides of the neck. The patient's general condition was approximately the same—B.P. 124/80, pulse 96, respirations 28 to 36, temperature 99 F., rectally, W.B.C. 10,000, E.K.G. was normal. His neck measured 18 inches in circumference at its largest point. He complained of pain in the neck on swallowing—cough was brassy and quite distinctive, and seemed to be produced by any slight exertion. There was tenderness over the neck anteriorly, and midsternum. Expectoration was bloody, and very thick and tenacious in character. He was entirely conscious and alert throughout the course of his illness. Ausculation of the chest revealed few râles in the right base, but no dullness. X-ray of the chest revealed pneumonitis (probably aspiration type) in the right base, with increase in superficial and deep cervical emphysema, as well as in the pneumomediastinum. Fig. 2. Auscultatory crepitation over the sternum was present, and on holding of the breath was found to be synchronous with the heartbeat—a pathognomonic sign of mediastinal emphysema (Eloesser's Sign).

On the third day, October 4, 1942, the swelling of the neck and chest was diminishing. The neck measured 17 inches in circumference, respiration 22 and pulse 72. Only complaints were pain on swallowing and hoarseness of voice. The brassy cough and bloody expectoration were present, but diminishing.



Fig. 1.—Chest taken October 3, 1942, showing moderate amount of cervical emphysema and beginning reflection of mediastinal pleura on right side.



Fig. 2.—Chest taken October 4, 1942, showing increase in amount of cervical emphysema and marked lateral displacement of mediastinal reflection of pleura on both sides. Also showing aspiration pneumonitis, right base.

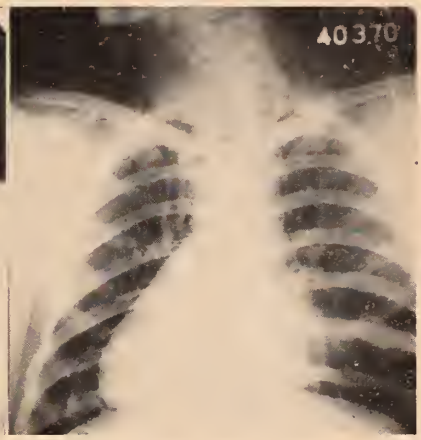


Fig. 3.—Chest taken October 6, 1942, showing some reduction in degree of cervical emphysema but persistence of mediastinal emphysema. Pneumonitis, right base, has cleared.

At 1:00 P.M. the patient was removed from the oxygen tent without embarrassment.

On the fourth day, October 5, 1942, the swelling and emphysema of the neck were greatly diminished. The neck measured 15½ inches in circumference. There continued the brassy cough and bloody expectoration, and hoarseness of the voice. Temperature was 98.8, pulse 76, respirations 22, B.P. 116/70, E.K.G. was again normal. X-ray of chest revealed clearing of the pneumonitis, right base; otherwise there was no change from the findings noted on October 4, 1942. Fig. 3. Improvement thereafter was rapid. All clinical signs of emphysema of the chest and neck had disappeared by October 9, 1942 (or the seventh day of illness). There was no further cough, and only slight hoarseness of the voice. X-ray of the chest at this date revealed marked reduction in the mediastinal emphysema, and emphysema of the deep and superficial tissues of the neck. Fig. 4.

On October 11, 1942, the patient suddenly coughed up three small pieces of fibrous tissue, each about 1 cm. in diameter. These were identified only as fibrous tissue, with no evidence of epithelium or other descriptive type

of cell structure. The sulfadiazine was discontinued at this time, after the patient had received a total of 50 grams, plus 3 grams of sulfathiazole. Atropine, gr. 1/150, q.4 hours was also given the first two days. A total of 4,000 c.c. of 5 per cent gluocose in physiological saline solution were given intravenously for the first three days. Sputum on October 5, 1942, revealed few gram-positive diplococci and numerous short chains of streptococcus. Blood Wassermann was negative. X-ray of the chest, taken on October 16, 1942—date of discharge from hospital—revealed complete clearing of all pathology. Fig. 5.



Fig. 4.—Chest taken October 8, 1942, showing marked reduction in degree of mediastinal emphysema.



Fig. 5.—Chest taken October 16, 1942, date of discharge, showing complete clearing of both cervical and mediastinal emphysema.

COMMENT

We believe this case to be interesting from at least two standpoints; first, the probable mechanism of production and, secondly, the management.

Although we cannot be sure as to the exact location of the site of the entrance of the air into the mediastinum, we believe that there occurred a rent in the trachea, or one of the larger bronchi some place close to the midline, as the degree of mediastinal pleura reflection was strikingly equal on both sides—as well as the cervical emphysema being distributed almost equally on both sides. Since there was no evidence of pneumothorax or lung tissue injury, the method of production in this case was probably direct entrance of the air into the mediastinum, either by the sucking action produced by respiration or more probably, we believe, by forceful expression of air from the trachea or a larger bronchus into the mediastinum each time the patient coughed, during which act a marked positive pressure would obtain within the trachea with the glottis closed momentarily.

In regard to the management of this case, which we think is the most important feature, heretofore one had to fear the development of mediastinitis with its grave sequela—mediastinal abscess. With the advent of sulfonamides, such fear is less warranted, especially if the sulfonamides be administered immediately upon discovery of the pneumomediastinum, as was done in this case and continued well along until all signs of further ingress of air into the mediastinum have disappeared, or marked reduction in the amount of emphysema has occurred.

Another point in the management is the relief of mechanical pressure upon the venous return of blood to the heart; namely, the superior and inferior vena cavae, as well as upon the heart itself. In cases where there is an associated tension pneumothorax, the treatment of choice is of course aspiration of the air from the pleural space; and in cases without the associated tension pneumothorax, the treatment generally accepted is incision over the suprasternal notch—allowing the air to escape through the opening; but if surgery of the latter sort is resorted to, one must not forget that the danger of mediastinitis is greatly increased.

Surgery was not necessary in our case, even though there was a marked degree of mediastinal air present. We believe that the fact the patient was almost immediately placed in an oxygen tent, thus facilitating the absorption of the nitrogen component from the mediastinal air and tissues of the neck spaces, may have been a factor in the rapid absorption of the emphysema without resort to surgery.

CONCLUSION

An interesting case of mediastinal emphysema with associated marked superficial, and deep

cervical and facial emphysema, is presented. It is thought that the opening between the air passages and mediastinum was located somewhere along the course of the trachea or larger bronchi, near the bifurcation of the trachea perhaps. Sulfonamide treatment was resorted to early, and the patient was placed in an oxygen tent almost immediately upon the discovery of the condition. The latter two procedures, we believe, are important in the conservative handling of such cases

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FERTILITY STUDIES IN BARREN MARRIAGES*

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IN the ultimate analysis, production of a child by a couple is the proof that both are fertile. However, the barrenness of a couple does not demonstrate the infertility of both, nor does it show which partner is incapable of procreation.

From the fact that husband or wife, or both, have previously had children it does not necessarily follow that fertility in either one or both is present at the time of examination. So-called "one-child sterility" is quite common; this, of course, is well known. In more than ten per cent of the married folk sent to me, either husband or wife had been a parent before the present marriage; and in approximately five per cent of the cases the couple had had a child several years previously, and during the present marriage.

Up to about ten years ago recognition of male fertility or infertility rested upon a careful history and physical examination, and a cursory semen analysis. If there appeared to be many spermatozoa, and these seemed to be moving about actively, the man was declared fertile and the onus of sterility placed upon the woman. The diagnosis, prognosis and treatment, with possible cure, were then assumed to be solely the responsibility of the gynecologist or obstetrician.

RECENT STUDIES

Scientific study of the semen has progressed greatly during the last decade, owing to the work of Moench, Hotchkiss, Cary, MacComber, and many others. Today there are certain standards that are generally accepted as criteria, within certain broad limitations, as indicative of normal male fertility.

A complete and thorough discussion of the qualifications requisite for normal fertile semen is not within the province of this paper. However, for an understanding of the semen findings in the series reported here, a few generally accepted facts may be stated.

The normal fertile man usually ejaculates from 2.5 to 6.0 c.c. of semen. It is of a creamy color, has a pH of 8.0 to 8.5, a certain viscosity and a distinctive odor. Variation in these characteristics does not necessarily indicate that the individual secreting it is relatively or absolutely infertile. Such deviation or deviations must be weighed in conjunction with other findings in the semen.

Most essential, of course, is a knowledge of the number and other characteristics of the spermatozoa in the semen. The normal fertile male's ejaculation will usually contain from 60 to 300 million spermatozoa per c.c. (Ten per cent must be allowed for possible error.) Of these, at least 50 to 70 per cent remain vigorously active for at least seven hours. Abnormal forms present should not exceed 20 per cent. These differing abnormal forms vary not only numerically in a percentage relative to the whole, but also relative to each other. The tapering form appears to be the one most consistently increased in number in men of lowered fertility. Moench takes 8.5 per cent to be the normal, any increase over this indicating impaired fertility.

A slight change in any of these essentials—number, motility, morphology—does not necessarily imply reduced fertility; but an extreme deviation in any one of them does.

Often, however, an opinion can be formed only after noting how much deviation is present in all characteristics. For instance, if the count of these cells per c.c. is 30-40 million, one would hesitate, on this finding alone, to state that the fertility of the individual was greatly reduced. But, if in connection with this, the motility was found to be diminished to 30 per cent, and there were present 20 per cent of abnormally shaped spermatozoa, one would certainly feel justified in deciding that impaired fertility had been demonstrated.

On the other hand, extreme deviation in any one characteristic—such as an oligospermia in which only an occasional sperm is found in many fields, or semen in which no motile sperm are shown, or the abnormally-shaped cells number 75 per cent of those present—any one of these alone, or similar deficiencies, would warrant a diagnosis of greatly-reduced fertility.

AUTHOR'S SERIES

The series of cases in this report includes only those in which there had been "involuntary" sterility for more than one year; and those in which relatively complete data on both husband and wife were obtained. The wife had been examined by the referring physician and, in his opinion, was adjudged fertile; this examination having demonstrated, of course, the patency of the fallopian tubes.

In determining the husband's causative share

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in the reported barren marriages, the family history and past history were recorded. In no case was anything found in the family history that appeared to have any significance relative to the patient's infertility.

The results of the physical examination (including indicated laboratory tests), the semen

TABLE 1.—*Causes of Barren Marriages*

		HUSBAND				
		Sole	Probable	Possible	Apparently fertile	
WIFE	Apparently fertile	93			48	141
	Possible		5	4		9
	Probable					0
	Sole					0
		93	5	4	48	150

analysis, together with the patient's history and the marital history, were all taken into consideration in the final determination of the relative responsibility of husband and wife. The results of these findings are given in Table 1.

The husband was classed as being the sole cause of the barren marriage when the examination left no doubt as to his infertility, and the gynecologist or obstetrician had found no pathology in the wife. He was definitely the sole cause in 93 cases and probably the cause of the barrenness in 5. He was classed as the probable cause when his fertility was greatly reduced and his wife showed some very slight pathology.

TABLE 2.—*Male Sterility in 150 Barren Marriages*

Causes		*No. of Cases*
Bilateral Vasectomy		1
Prostatitis		2
Syphilis		2
Testicular Trauma		5
Faulty Development		7
Cryptorchid	4	
Hypogonad.	3	
Mumps Orchitis		8
Gonorrhea		8
Unknown		65
		98

In the four cases in which both husband and wife were placed in the "possible" column, three of the wives had very slightly eroded cervices and the fourth a very small pinpoint os. As those conditions, in themselves, were not considered a sufficient cause, the husband, although his examination indicated fertility, was listed as a possible cause. These four were not included as definitely male infertility cases, although possibly, they should have been included under the "apparently" fertile group.

The 48 couples, in which both man and wife were "apparently" fertile, had been married for periods varying from 1 to 13 years. Twelve out of this group had never attempted to prevent impregnation and in these twelve, as well as the rest of the group, active spermatozoa were found well up in the cervical canal 2 to 4 hours postcoital. The length of time of "involuntary" sterility of these 48 couples varied from 1 to 13 years. Of the 48 apparently fertile couples, two had been married for 13 years. One of these couples had never used contraceptive measures and the other had used them for 12 years previous to the last year of their marriage.

Table 2 shows the causes of reduced fertility in the male, in those cases in which the husband was probably the sole creatively deficient factor in the childless union.

Cases were classified as due to an unknown cause only when the past history, and a careful clinical and laboratory study gave no clue to the etiology.

Prostatitis was not given as a cause except in those cases in which the secretion expressed from the gland was loaded with pus cells, and contained few normal prostatic elements.

Of course a history of gonorrhea alone did not suffice to place this disease in the listing as a cause. Gonorrheal epididymitis accounts for seven of these cases, the eighth being a severe gonorrheal stricture of the posterior urethra which left a distorted and scarred verumontanum with no visible ejaculatory duct openings. It is not improbable that instrumental trauma may have resulted in this obstruction to the ducts.

Syphilis was noted as a causal agent, only because both patients had been told during the acute stage of the disease that the testicles were affected. The testicles of one of them were still very hard and firm, and he had a positive Wassermann reaction. When promptly and efficiently treated, syphilis in the male rarely affects fertility.*

SUMMARY

One hundred and fifty barren marriages have been studied in an attempt to determine to what extent the husband had contributed to, or been responsible for, the childlessness in these marriages. In the opinion of the referring physician the wives were fertile.

Ninety-eight, or 65 per cent, of the men showed definitely reduced fertility. In 65 of these the

* Unpublished Author's Survey.

cause of the reduced fertility could not be determined.

In 93 of the whole group of barren marriages it could be definitely stated that the husband was the sole cause; and in 5 instances he was *probably* the cause. However, in 48 cases, or practically one-third of the cases, as judged by our present criteria, both husband and wife were fertile and should have had children born to them during their marriage, yet they were childless.

CONCLUSIONS

It is evident from this study that our knowledge and ability for diagnosing fertility in both male and female is far from complete.

Much of the advance in this field has been made possible by the coöperation between the referring physician, usually a gynecologist or obstetrician, and the urologist.

This association should be developed so that a thorough study is made of both husband and wife in every barren couple. The findings of the gynecologist, obstetrician and urologist may then be pooled, inaugurating proper joint study.

We would have not only more reliable statistics as to the relative responsibility of man and wife, but improved diagnosis and treatment.

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CARCINOMA OF THE PROSTATE: RECENT ADVANCES IN ITS TREATMENT*

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UNTIL recently, the treatment of the metastasized malignant prostate has usually been approached by the attending physician with a feeling of helpless futility. After establishing drainage, and possibly instituting radiation, we had largely exhausted our therapeutic armamentarium. For pain, the increasing frequent need of the narcotic was often not adequate. Mute evidence of this fact is witnessed by the use of various procedures such as cordotomy, sympathectomy, and the alcohol injection of nerves for the relief of pain.[1, 3, 6, 7]

PATHOGENESIS AND TREATMENT

While many have contributed to various attacks on the problem,[4, 8, 17, 14] the recent work of Charles Huggins and his associates[10, 11, 12] has done much to clarify our present knowledge as to the pathogenesis and treatment of this condition. The treatment based on an endocrine aspect is still largely in the experimental phase.

Huggins[12] maintains that carcinoma of the prostate is composed of epithelial cells of a mature type, which are "responsive to depression of the level of androgenic hormone in the organism." By injecting androgen into the system, this activity can be increased. On the other hand, this level can be depressed by the removal of the testes, by inactivating the androgens by estrogen, or by drugs having estrogenic-like effects, such as di-ethyl-stilbestrol.

A number of investigators,[9, 11, 14, 16] studying the relation of carcinoma of the prostate with metastasis, have found the acid phosphatase to be abnormally high in most instances. Huggins has used this as an objective proof in determining the effect of androgen or estrogen in the activity of this enzyme. Thus estrogenic-like substance, such as stilbestrol, when administered, shows marked depression of the serum acid phosphatase level; and when the drug is discontinued, a rise of the acid phosphatase curve is seen. Huggins[13] states dogmatically that "when the acid phosphatase is greatly increased above 10 units, cancer of the prostate with metastatic involvement has always been present, but metastatic involvement may occur without elevation of the serum acid phosphatase. Where the acid phosphatase levels are maintained in certain cases following castration, it is believed to be due to the formation of androgen in extratesticular regions, such as the adrenal cortex and anterior pituitary gland.

"The mechanism by which estrogens reduce the elevated acid phosphatase of serum in carcinoma of the prostate is susceptible of several explanations, which include a direct attack on prostatic epithelium, inactivation of the androgens, depression of the gonadotropic agents of the anterior pituitary, and depression of the interstitial cells of the testes."[13] Castration appears to be the surest way to eliminate the genadal androgens of the testes as a factor. Since androgens may be produced in significant amounts outside the testes, estrogen therapy should also be instituted.

SOURCE MATERIAL

Thirty-one cases of carcinoma of the prostate treated during the past year by castration, estrogens, stilbestrol or a combination of all, are briefly summarized. These patients all complained of some form of pain, varying from minor aches in the back and legs to extreme pains relieved only by opiates. The results obtained seem almost unbelievable—only three cases of this group failing to obtain relief from pain by castration or stilbestrol therapy. Twenty-four of the thirty-one cases were treated by bilateral orchidectomy, the remaining seven being treated by the acid esters of one of the natural estrogenic hormones known as di hydroxy estrin (estradiol di propionate), administered intramuscularly, and di ethyl stilbestrol, an estrogenic-like substance. The latter has the advantage of oral administration and low cost.

All but four patients had some associated urinary retention, which was relieved by transurethral prostatic resections. The pathological report of sections revealed over one-half of these

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cases to be a grade III malignancy, and two cases were graded as IV.

Three deaths in this series occurred within a month following castration in practically moribund patients suffering from intractible pain. Subsequent relief from pain was associated with a definite change in mental attitude to one of cheerfulness and grateful appreciation.

Seven patients previously unable to work have improved sufficiently from their pain and disability to permit them to return to their previous activities. Several, which were practically confined to their beds before treatment, have since been able to carry on light work around the yard.

In several cases it was necessary to discontinue stilbestrol administration, due to nausea; but utilizing the enteric coated tablet proved effective in eliminating this factor.

Heavy radiation through the pelvis and testicles was instituted in four cases, a procedure advocated by Counsellor[5] and Munger.[15] The results in these cases have not been as satisfactory or spectacular as that obtained following castration and estrogen therapy.

The dosage of stilbestrol used in this series has been relatively small: 3 mg. daily for the first few days, and subsequent reduction to 1 mg. daily, has been prescribed. If pain tends to persist, the dosage is doubled. A maximum of 18 mg. daily has been used without untoward effect of the drug, in one case.

Comparison of sections of prostatic tissue, from four cases studied by Dr. Albert Brown,[2] Pathologist at the Los Angeles County Hospital, showed "no definite qualitative change in the tumor, except in one case. In this instance the subsequent biopsy revealed advanced necrosis of the tumor, with extreme lymphocytic infiltration. Many of the tumor cells appear to have become syncitial giant cells, with clustered piknotic, distorted nuclei. In general, the quantity of tumor shown in the sections is considerably less than the post therapeutic biopsies. Another change noted is squamous metaplasia principally or entirely confined to the nonneoplastic prostatic glands incidentially present." The following clinical history refers to this case:

REPORT OF CASES

Case 1.—Initials, C. V. Age 71. Complaint: For years this patient suffered from pains in the hips, ribs and back, which have grown progressively more severe. Three months ago urinary retention developed, and transurethral prostatic resection was done. Pathological examination of the prostatic tissue at that time revealed a grade III adeno carcinoma. The prostate, rectally, was typically malignant. Castration failed to relieve the pains until one week later, when stilbestrol therapy was instituted and his pains disappeared. The patient is now able to enjoy foods which he was unable to eat before, and he is steadily gaining weight. When stilbestrol therapy was instituted, 3 mg. daily was prescribed for the first week. Gynecomastia was noted, and the drug was stopped for two days. However, pains again began to recur and 1 mg. daily was again prescribed. Since that time the patient has felt entirely comfortable and has returned to work. No libido has been noted since the institution of treatment. Microscopic biopsy was taken three months after castration and stilbestrol therapy were instituted.

* * *

Case 2.—Initials, G. C. Age 61. Patient suffered from symptoms of prostatism, with back and leg pains, for six years. Transurethral prostatic resection done two years earlier was again repeated. Pathological sections revealed a grade III adeno carcinoma of the prostate to be present on both occasions. Castration and stilbestrol therapy were instituted, with prompt subsidence of pain. The prostate by rectal palpation, after three month's treatment, could not be recognized as malignant, although it had been typical of malignancy previously. Clinically, the patient now appears entirely well and is carrying on his normal activity. Biopsy sections of the prostate taken three months later showed no apparent tissue change. He still has a grade III malignancy.

* * *

Case 3.—Initials, H. S. P. Age 59. This patient complained of severe aching pain in both inguinal regions and across the back, frequency of urination, dysuria, slowness of the urinary stream, and considerable loss of weight during the past six months. There was marked enlargement of the left inguinal node, which was freely movable. The prostate by rectal palpation was enlarged, grade II, hard, irregular and fixed. Two ounces of clear urine were obtained. Transurethral prostatic resection, for palliative relief, was done, and deep x-ray advised. Pathological report revealed adenocarcinoma of the prostate, grade IV. His convalescence was uneventful, but the patient did not feel that he was gaining strength as rapidly as he should. Pain in the hips and legs was relieved by use of barbiturates at first, but finally required opiates for relief. X-ray through the pelvis and groin, and the use of liberal morphine, gave only transient relief from pain. A hard nodule, the size of a walnut, developed in the left inguinal region, and edema of the left leg and lower abdomen was marked. After two weeks of intensive radiation, patient still had little relief of pain, but some indication of diminution of the swelling in the leg was noted. One month later the swelling of the leg again became more marked and began to be noted on the right leg and pubic region. H.M.C.'s No. 1, every 4-5 hours, were taken for pain. The right supraclavicular node became greatly enlarged, and the patient complained of radiating pains across the neck and even across the vertex of the skull. Patient was evidently failing rapidly, but came into the office, by the assistance of his wife and the use of two canes. Bilateral orchidectomy was advised, but patient refused this. He did, however, consent to heavy radiation of the testicles which resulted in some transient improvement. 3 mg. of estradiol dipropionate, three times a week for two weeks, resulted in a marked relief from his pain. The edema was notably diminished in the left leg and the swelling in the sternoclavicular region disappeared. 1 mg. injections, three times a week, for two months were given, and patient discontinued the use of opiates entirely. The last narcotic prescription was written five months ago, and patient now states that he has eight tablets left. Patient is able to do light work around the yard and enjoys surf-fishing. His outlook on life is cheerful, he has put on considerable weight and looks well, and his family is very much encouraged. Examination of the prostatic bed reveals no evidence of hard nodules suggestive of malignancy. The testicles appear atrophic, but patient states libido apparently has been uneffected. Biopsy section of the prostate, taken seven months after instituting estrogenic therapy, failed to reveal any notable changes present in the tissue examined.

COMMENT

Hope and encouragement can be given to the patient with carcinoma of the prostate. Pain has been relieved in nearly 90 per cent of cases by the utilization of hormonal factors in its treatment. Improvement in appetite and gain in weight have been noted. Actual regression in the size of the gland has been noted after several months' treatment. The disappearance of metastatic nodules in the chest and bones has been demonstrated by some, although none have been noted in this series.

What the future holds for these patients remains yet to be seen. Whatever the ultimate outcome may be, hormonal therapy has offered a grateful respite to many who have already entered the "valley of the shadow of death."

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HYPOTHYROIDISM—LATENT SYMPTOMS*

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DESPITE the present emphasis on early recognition of disease processes and the vogue for preventive medicine, hypothyroidism is rarely detected in its earlier stages and milder forms, and usually not until the most advanced findings have developed. Many text books describe hypothyroidism only in its outspoken manifestations, and imply that all of the classical symptoms should be present—namely, the combination of generalized myxoedema, dwarfism, if it has arisen in childhood, severe osseous retardation, marked hair and skin changes, great somnolence, constipation, retarded mental development, and a very low basal rate.

Ordinarily hypothyroidism occurs as a very mild deficiency, progressing insidiously but persisting permanently. Such cases are far more common than the florid types customarily described. The pathogenesis is mainly governed by the possible interrelationships of the following factors: the age of onset, the degree and tempo of the deficiency, and the response or reactivity of the various body tissues. The degree of deficiency may be progressive or sometimes cyclic, characterized however by exacerbations rather than remissions. Such intensifications are due, as a rule, to intercurrent infections. Usually the tempo is slow and continuous, but may be very rapid as after a thyroidectomy.

Naturally, better therapeutic results will follow if the deficiency can be apprehended in its earlier stages, and before it has been in existence for too great a time. The most important therapeutic desideration, in childhood for instance, is to prevent or improve mental deficiency rather than to be chiefly concerned with the eradication of the disease's physical stigmata.

Very significant is the tissue response to the deficiency. This endocrinopathy can affect all parts of the body. However—and this is important to recognize—not all tissues react equally to lack of thyroid hormone. As a matter of fact, myxoedema is rarely present in the early phases of the disease; not everyone develops anemia; a few will have ascites only, or joint pains only, or thickened tissues about the vocal cords only, or only menorrhagia, as the earliest, and sometimes the only manifestation for a long while in the early period of deficiency. Such partial clinical pictures may remain unchanged for months and even years, or again they may blossom with the further development of classical stigma in other parts of the body, finally flowering into the full-blown text book picture. Such latter cases are in the minority among patients suffering from hypothyroidism.

How, then, is this intangible and early deficit to be recognized? This stage cannot be qualified

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by certain "sine quo non" or "must phenomena," so often exactly stated, as for instance, in early diabetes—glycosuria, ketonuria, hyperglycemia, etc. There is hardly one subjective or objective finding, or laboratory test, which either excludes or substantiates the diagnosis of incipient hypothyroidism. Even a profoundly low basal metabolic rate can occur in severe anorexia nervosa, Simmond's disease, Addison's disease, hypogonadism or tubular nephitis, and a normal metabolic reading does not necessarily rule out an early mild deficiency. Moreover repetition of the test may yield a lower percentage. The clinician must rely principally on a critical analysis of the objective and subjective findings, and only secondarily on laboratory aids, and the latter should not be permitted to outweigh or sway his clinical experience, acumen and judgment.

A few terse clinical résumes will perhaps illustrate the diagnostic problem and aid in its solution.

REPORT OF CASES

Case 1.—A young man of 21 years had a mild deficiency, since his second year; no treatment for the past five years. His features were slightly but definitely myxoedematous, the metabolic rate was 15 per cent minus. Is hypothyroidism to be ruled out because his bone age is between 18 and 20 years, his I. Q. 80 per cent and because there were no other striking complaints or stigmata? Treatment with thyroid extract altered his appearance, improved his vigor, enlivened his personality and drowsiness, cleared his husky voice and eliminated aches in his joints. Properly-controlled thyroid therapy often aids in establishing the diagnosis which prior to the therapeutic test was but a tentative one.

Case 2.—A 24-year-old lady complained only of stiffness of the knees for some years. She was markedly dwarfed, slightly obese, markedly myxoedematous, her pulse and blood pressure were low, mentality was that of 12 years, bone age of 10 years, basal metabolic rate was 39 per cent minus, and there was a very definite anemia (Hb. 60 per cent, R.B.C. 3,560,000). The transformation during 10 months of thyroid treatment was miraculous. The sole complaint and reason for seeking a physician was stiffness in the knees, yet here were many classical findings slowly developing over many years. The hypothyroidism had originated during early childhood and had been neglected for years.

Case 3.—Another example of the isolated manifestation is the following: A 51-year-old woman had suffered from attacks of paroxysmal tachycardia for 17 years, and between attacks was found to have a pulse rate of 50 and inverted T waves in all leads. On closer examination she presented many classical clinical signs of adult myxoedema, together with a basal metabolic rate of 31 per cent minus. Under thyroid therapy not only the myxoedema disappeared, but a remarkable improvement occurred also in the cardiac condition which resulted in a transformation of inverted into upright waves in the electrocardiogram. While cardiac myxoedema may not have accounted for her tachycardia, thyroid therapy was responsible for the cardiac improvement.

Case 4.—Occasionally one has to look long and intently at the facies to detect mild deviations which may have been present for years: A 20-year-old girl, ever since the menarche at 18 years, had had very bothersome menometrorrhagia, yet, on physical examination, outside of a slight puffiness about the eyes and nose, there was nothing to indicate thyroid deficiency. The basal rate was 25 per cent minus. The beneficial response to thyroid therapy corroborated the suspicion of thyroid lack. Left to the natural course of the disease this girl, eventually, over the future years, might have developed far more serious evidence of thyroid failure.

COMMENT

Latent hypothyroidism, accompanied by nervousness, is an odd and almost paradoxical form of deficient function. The nervous cretin, well described in the literature, is a different entity. The former type is sometimes seen in the tall, thin adolescent girls whose basal metabolism is between 10 and 20 per cent minus. Thyroid extract relieves the nervousness, raises the basal rate, is attended by weight gain and a more normal maturity. In some of these cases the thyroid inadequacy may be secondary to a primary hypogonadism.

As Lisser[1,2] phrased it, "Learn ye well the conspicuous peculiarities, capricious vagaries and hidden hints of thyroid failure, and much misery will be spared your patients and much satisfaction added unto you."

SUMMARY

Latent, mild, masked, hypothyroidism is the more common form of deficiency. The course of the disease depends on the age of the onset, degree and tempo of the deficiency, and the tissue response. The classical descriptions of childhood and adult myxoedema, cretinism and of hypothyroidism in general, represent for the most part an outspoken degree of deficiency of long duration. It is possible now as a part of preventive medicine and better therapeutics to pool and closely consider subjective and objective findings, and thus diagnose hypothyroidism earlier in its history.

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Legislative Record of the Seventy-seventh Congress*

The Seventy-seventh Congress adjourned December 16, 1942, after having been in continuous session since January 3, 1941. During this time numerous bills of medical interest, a few of major importance, were considered by the Congress, a large majority of which failed to receive favorable action. In fact, few measures of medical interest passed other than those associated with the general war effort. This should occasion no surprise, for the recent Congress functioned through turbulent times. First the imminence of war and then its actuality necessarily focused sharply the attention of the

* From the A.M.A. Federal Legislative Bulletin, No. 23, J. W. Holloway, Jr., Director.

* For additional news concerning recent legislation, see in this issue, on page 79. For editorial reference, see page 59.

lawmakers on programs pointing to our national security. Other matters received only secondary consideration.

A brief summary of the action taken by the Congress on some of the proposals previously reported in earlier issues of the *Bulletin* follows.

The bill that was introduced to protect diabetic patients from impure insulin became a law. . . .

Proposals were submitted to the Congress to authorize the expenditure of federal funds to investigate the cause of encephalitis lethargica, to provide better facilities for the treatment of cancer and tuberculosis, to auhorize the United States Public Health Service to conduct investigations in relation to dental diseases, and to effect a better control of occupational diseases in general and silicosis in particular but none of these bills were enacted. Congress did complete action on the May bill prohibiting prostitution within such reasonable distance of military or naval establishments as the Secretaries of War and Navy may determine to be needful to the efficiency, health, and welfare of the Army and Navy. This measure, of course, has for its objective a reduction in the venereal disease incidence in the armed forces.

Federal funds, to the extent of $5,000,000, were made available for loans to students pursuing accelerated medical courses and certain other designated technical courses. Likewise additional funds were made available to the United States Public Health Service for the training of nurses to augment the supply depleted by the demands of the military program.

Numerous bills were submitted to broaden the field of operation of the Social Security Act. . . . Late in the session Representative Eliot introduced his bill to amend and extend the provisions of the Social Security Act to include, among other things, sickness and hospitalization benefits. While this measure was apparently not officially sponsored, it did undertake to effectuate some of the recommendations submitted by the President in his Budget Message in the early days of the Congress. No action was taken on the bill and it died in the House Committee on Ways and Means.

The Congress took no action on bills to establish a Chiropody Corps in the Medical Corps of the Army and to require the appointment of a chiropodist in each base hospital or training camp. Meeting similar fates were proposals to establish a Pharmacy Corps in the Army. . . . During the early days of the Congress legislation was proposed to open the ranks of the Army Medical Corps to graduates of unapproved medical schools, but no action was taken on it.

Persistent efforts were made by the chiropractors to secure the enactment of the Tolan bill to amend the United States Employees' Compensation Act so as to authorize adherents of this cult to treat beneficiaries of the act, the bill being identical with the measure sponsored by Representative Tolan in the Seventy-sixth Congress. This legislation died on the calendar of the House of Representatives. The osteopaths were likewise persistent in their demands for recognition at the hands of Congress and were successful to the extent that the Surgeon General of the Army was *authorized* to appoint osteopaths as interns in army hospitals and to the extent that *authorization* was included in a bill providing appropriations for the Navy Department for the use of funds "for the pay of commissioned medical officers who are graduates of reputable schools of osteopathy." . . . The authorizations given by the Congress are *permissive* in form only.

While the so-called Wagner-George hospital construction bill received no consideration by the Congress, the Lanham bill became a law by virtue of which considerable federal funds were made available for the construction, in distressed areas, of needed public works, including hospitals, health facilities and clinics. Under this legislation, hospitals, clinics and other health facilities were augmented in many States in areas where existing facilities had proved totally inadequate to serve the influx of population due to defense activities. Additional funds, too, were made available to the Veterans' Administration, $4,557,000 to be exact, for major reconditioning, replacements and new construction of hospitals and domiciliary facilities for veterans. . . .

The President submitted to the Congress a recommendation for such additional appropriations as the Children's Bureau might need during the emergency for allotment to the States for maternal and child welfare purposes. Some of this money, it was contemplated, was to be used in providing medical, hospital, obstetric and pediatric care for the wives and children of men in military service. Companion bills were introduced to effectuate this recommendation but Congress failed to act on them. The Children's Bureau did, however, set aside a part of its regular appropriations for allotments to the States to provide the indicated services for the wives and children of servicemen.

A bill proposing to establish a Federal Department of Health in which could be combined the public health activities carried on by the various branches of the Government failed of enactment. Likewise no action was taken on another bill, sponsored by the Federal Security Agency, to effect a reorganization of the United States Public Health Service.

During the closing days of the Congress legislative action was completed on a Treasury Department initiated measure to regulate the growing of opium poppy in the United States and to provide for the manufacture of opium from the plants. . . .

Another measure enacted during the last days of the Congress increases the pay, allowances and rank of the Army and Navy Nurse Corps and authorizes the employment by the military establishment of and accords a military status to female dietetic and female physical therapy personnel. This law, too, authorizes the employment of other technical and professional female personnel in categories required for duty outside the continental United States.

The Congress took one more step looking toward the provision of adequate housing for the Army Medical Library when it authorized an additional appropriation for the purchase of a site for the building. Apparently, however, this urgent project will not be carried to completion until more settled times.

The new Revenue Act will greatly increase the tax burden of physicians as it will other federal income taxpayers. It does not effect any changes in the deductions that a physician may claim on account of professional activities It does impose an obligation on physicians who have in their employ persons receiving wages in excess of $12 a week a duty of withholding the Victory Tax. The new act eliminates an injustice that has obtained for a number of years in the manner in which outstanding accounts on the books of a taxpayer at the time of his death have been treated for income tax purposes. Hereafter such unpaid accounts will not be considered as part of the income of the decedent for the year of death, as has heretoforc been the case, but will be taxable when paid, as a part of the income of the person who receives the money. A provision in the new law authorizes a taxpayer to deduct amounts expended for medical, dental and hospital care to the extent that such expenses exceed 5 per cent of the net income of the taxpayer but not in excess of $2,500 in case of the head of a family, or $1,250 in case of other individual taxpayers.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

California Procurement and Assignment Service

Following the suggestion made at the January 12-13 meeting of Procurement and Assignment Service in San Francisco by national officers of that service, Dr. Harold A. Fletcher, California State Chairman for Physicians, has appointed a Coördinating Committee for the consideration of problems of medical care in California.

This committee has already held several meetings and is planning weekly sessions, at least for the time being, for the consideration and solution of situations of acute medical shortages which now exist or might come about in California. The first situation under discussion is that in Richmond, where a population of some 90 000 people has grown out of a prewar population of 20,000 and has put a serious strain on the existing medical resources.

Object of the Coördinating Committee is to bring into one group all the resources of agencies with a knowledge of and interest in the field of health service. Washington officials of Procurement and Assignment Service have urged a closer coöperation between these agencies as a means of solving problems which one agency or another might not be able to handle by itself.

Membership of the Coördinating Committee consists of:

Harold A. Fletcher, M. D., Chairman; California State Chairman for Physicians, Procurement and Assignment Service.

W. T. Harrison, M. D., Medical Director, U. S. Public Health Service.

Wilton L. Halverson, M. D., Director, California State Department of Public Health.

Albert E. Larsen, M. D., Medical Director, California Physicians' Service.

Morton Gibbons, Sr., M. D., Medical Director, California State Council of Defense.

L. P. Foard, M. D., Regional Medical Officer, Office of Civilian Defense.

Ernest Sloman, D. D. S., Dental Chairman, 9th Corps Area, Procurement and Assignment Service.

John Leggett, D. D. S., California Chairman for Dentists for Northern California, Procurement and Assign-

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

U. S. Army Medical Corps Recruiting Boards are in charge of Major F. F. South, M.C., at Room 1331, 450 Sutter St., San Francisco (EXbrook 0450), and Major C. A. Darnell, 1930 Wilshire Boulevard, Los Angeles (DRexel 5241).

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. L. C. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone EXbrook 3386, Local 46.

For the southern section of the State, the Office of Naval Officer Procurement is in charge of Lt. Comdr. John P. Ewing, MC. The office is located at the Naval Armory, 850 Lilac Terrace, Los Angeles.

For roster of Procurement Service Committees of County Medical Societies, see July Issue of CALIFORNIA AND WESTERN MEDICINE, on pages 93-94.

ment Service.

Karl A. Schaupp, M. D., 9th Corps Area Chairman, Procurement and Assignment Service.

Milton Rose, M. D., Regional Director, Red Cross Unit.

George C. Hahn, D. D. S., President, California State Dental Association.

Anthony J. J. Rourke, M. D., Superintendent, Stanford Hospital.

William P. Shepard, M. D., Metropolitan Life Insurance Co.

Procurement of Medical Officers for the Army in 1943

NOTE.—*The following is an official statement from the Medical Corps of the United States Army indicating the procedure to be followed in procuring medical officers for the Army during 1943.*

The Surgeon General is responsible for the procurement of medical officers for the Army of the United States. There is an Officer Procurement Service set up by the War Department for the procuring of applications of individuals for commission in the Army. The War Manpower Commission has set up a Procurement and Assignment Service for Physicians, Dentists and Veterinarians to designate the individuals who are essential to the community and those available for duty with the armed forces.

In order to coördinate the work of these two agencies, the Surgeon General has outlined the following procedure for the procurement of officers during the year 1943:

The State chairmen of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians will from time to time prepare lists of individuals who are declared available for duty. Their names will be sent to the Central Office of the War Manpower Commission in Washington, D. C. There a card will be prepared and sent to the individual informing him of the fact that he has been classified as available for military service and requesting that he send the attached card to the State chairman of the Procurement and Assignment Service signifying his interest in applying for a commission, and stating his preference for duty with the Army or Navy. Those who choose to serve in the Army may request that their papers be processed with the idea of assigning them to duty with the Air Forces.

The State chairmen will furnish the candidate to the designated field office of the Officer Procurement Service of the War Department. This office will request the individual physician, dentist or veterinarian to complete the proper application blanks and return them to that office and to have a final type physical examinatiton, which will be accomplished at the nearest properly equipped army post.

The Officer Procurement District's office will forward the papers to the Surgeon General in Washington, who will then review the application for commission in the Medical Corps, Army of the United States. Those applications with the notation "Air" as designated will be referred to the Office of the Air Surgeon for further classification and assignment. Those applicants who are favorably considered will be notified at the earliest possible date by the Office of the Adjutant General that their recommendation is accepted and will receive orders to proceed to their proper station.

It is hoped by following this procedure that the Surgeon General will be able to provide an adequate medical service for our armed forces. It is contemplated that all individuals who are classified as essential to the civilian medical needs will not be asked to apply for a commission. No individual so classified need contact the Surgeon General or apply for a commission unless he can make arrangements with the State chairman of the Procurement and Assignment Service to have his classification changed from essential to available. The coöperation and interest of all physicians who are interested in military medical service will be appreciated, in that by proper application and processing of their case it will be much easier to provide necessary medical care for all parts of both the civilian and military services.

Concurrent with the changes in the military and civilian requirements for physicians and the changes in the recruiting procedures, the Surgeon General has announced the following policy, which will govern action to be taken in the consideration of ages and grades of initial appointments on all applicants effective February 15, 1943:

1. Eligible applicants for appointment in the Medical Corps, Army of the United States, under the age of 38 will be appointed in the grade of first lieutenant only.

2. Eligible applicants between the ages of 38 and 55 will be appointed in the numbers and in the grade for which specific position vacancies exist.

There is an acute need for medical officers under 38 years of age. Applications are being solicited from physicians of this age group in those localities that have not furnished their quotas of physicians and where they are designated by the Procurement and Assignment Service as available for military service.

Appointments will be made by the Adjutant General of eligible applicants recommended by the Surgeon General and approved by the Secretary of War's Personnel Board.—*J.A.M.A.*

U. S. Treasury Regulations No. 5: Concerning Prescribing of Narcotics by Physicians in Military Service

State of California
Department of Penology
DIVISION OF NARCOTIC ENFORCEMENT
San Francisco, January 29, 1943.

Dear Doctor Kress:

We have just received a copy of the amendments made to Regulations No. 5, of the U. S. Treasury Department, concerning the prescribing of narcotics by officers of the medical corps of the Army and Navy of the United States.

Since these amendments will be of interest to members of the medical profession, we are enclosing herewith a copy of the amended regulations. Would you please publicize these changes in the next issue of your publication?

With best personal regards, I remain,
Very sincerely,
PAUL E. MADDEN, *Chief,*
Division of Narcotic Enforcement.

* * *

TITLE 26—INTERNAL REVENUE
CHAPTER 1—BUREAU OF INTERNAL REVENUE
(T. D. 33)

Part 151—Regulations Under the Internal Revenue Code Relating to Narcotics

(Regulation No. 5)

Importation, Manufacture, Production, Compounding, Sale, Dealing In, Dispensing and Giving Away of Opium or Coca Leaves or any Compound, Manufacture, Salt, Derivative, or Preparation Thereof.

Amendment to Joint Narcotic Regulations Made by the Commissioner of Narcotics and the Commissioner of

Internal Revenue with the Approval of the Secretary of the Treasury.

Section 151.95 of Part 151—(Regulations Under Chapter 23 and 27 of the Internal Revenue Code), Article 95 of Bureau of Narcotics Regulations No. 5, dated June 1, 1938, is hereby amended by adding thereto the following:

Officers of the medical corps of the Army and Navy, in the course of official medical treatment of Army and Navy personnel and members of their families entitled to receive such treatment, are required to issue prescriptions for these patients which may call for narcotic drugs or preparations. Under circumstances where the drug or preparation required by the patient for medical use cannot be furnished from official stocks, it is necessary that it be obtained, pursuant to the official prescription, from a drug store duly qualified by registration under the Federal narcotic law to fill narcotic prescriptions.

Such prescriptions, issued in the course of official professional practice only, and prepared on official blanks or stationery (such as printed forms of an army or navy hospital or dispensary) and otherwise meeting the requirements of Narcotic Regulations No. 5 (Part 151, Chapter I, this Title), relating to narcotic prescriptions, may be filled by a duly registered druggist although they do not bear a registry number of the issuing practitioner; provided they bear the signature, title, corps and serial or jacket number of the issuing medical officer. Such prescriptions when filled, shall be filed with, and retained for the same period as narcotic prescriptions issued by regularly registered practitioners and filled by the druggist.

This procedure shall not apply in the case of prescriptions written by an army or navy medical officer in the treatment of a private patient, i.e., a patient not entitled to receive medical treatment from the physician in the latter's capacity as a service medical officer. In prescribing and dispensing narcotic drugs to such private persons, the officer is subject to all the requirements of the Federal narcotic law, including registration and payment of tax, as are imposed upon other physicians conducting private medical practice.

(Signed) H. J. Anslinger,
Commissioner of Narcotics.

(Signed) Guy T. Helvering,
Commissioner of Internal Revenue.

Approved: December 21, 1942.

(Signed) Herbert E. Gaston,
Acting Secretary of the Treasury.

48 American Doctors Die in U. S. Service in 1942

Forty-eight U. S. physicians died in military service in 1942, eleven of them in action, the *Journal* of the American Medical Association reported recently.

The *Journal*, in its annual compilation, said there were at least 3,353 deaths of physicians in this country during the year.

The average age at death was 65, as compared with 65.9 in 1941.

"Medical Journal Abstracts" for Physicians in the Armed Forces

In the *Journal American Medical Association*, dated January 23, 1943, a note appears that E. R. Squibb & Sons is distributing to physicians in the armed forces a publication, *Medical Journal Abstracts*. . . .

Medical Journal Abstracts attempts to cover the entire field of medicine and to issue abstracts the *month following date of publication* whenever practicable—the notable exception of course being those periodicals which are printed elsewhere than in the United States. At present more than 165 periodicals are represented and the list is being extended. *Medical Journal Abstracts* is strictly altruistic in its objective and contains no advertising. It is sent only to physicians in the armed services, and is now reaching an appreciable percentage of those in this country and a number overseas.

U. S. Army Will Train Doctors As Specialists

Secretary of War Stimson recently announced a series of special courses whereby several thousand additional army medical and dental officers "will become sufficiently qualified to overcome an acute shortage" in many groups of specialists.

At his press conference, Stimson disclosed the courses will begin January 1st and from 200 to 400 officers will be selected for each class.

"The distribution of professional medical men trained for medical and surgical specialties," he said, "has proved inadequate to meet the demands of war."

However, the secretary added, there are a number of army medical corps officers who could "with a short intensive course, become qualified in a particular specialty, help eliminate the deficit in that specialty."

Stimson said the medical courses for army doctors will be provided at the schools of medicine of the following civilian institutions:

University of Illinois, Northwestern University, Columbia University, University of Pennsylvania, Harvard University, Washington University (St. Louis, Mo.), University of Michigan, Johns Hopkins University, University of California, Stanford University, University of Oregon, Duke University, Lahey Clinic, Boston; Mayo Foundation, Rochester, Minn.; Tulane University, University of Wisconsin, University of Tennessee, University of Chicago, University of Minnesota and Ohio State University.

Military Clippings—Some news items of a military nature from the daily press follow:

10,000 Doctors Will Join Armed Services in 1943

Washington, Jan. 9.—(AP.)—The War Manpower Commission disclosed today 10,000 more of the Nation's 180,000 physicians will be taken by the armed forces in 1943 and said this will leave "more than 80,000" doctors for the civilians.

Chairman Paul V. McNutt promised every effort to provide adequate medical care for civilians, partly through voluntary relocation of doctors to areas of greatest need.

Dr. Frank H. Lahey, chairman of the directing board of the W.M.C.'s procurement and assignment service for physicians, said 80,000 active civilian physicians "is a sufficient number to care for the needs of the civil population if these men and women are properly distributed and allocated and if civilians will take every possible health precaution to keep well."

Doctor Shunning Army Is Ordered Drafted

Chicago, Jan. 9.—(INS.)—Because he did not make application for a commission in the army medical corps, a Chicago physician has been ordered to report to his draft board for induction as a private, it was disclosed today by Lieutenant Colonel E. Mann Hartlett, Illinois selective service medical director.

It is one of the first actions of the kind in the country, Colonel Hartlett said.

The doctor affected by the order had been declared available by the physicians procurement and assignment service last July, but failed to apply for a commission and his draft board was advised to induct him.—Fresno *Bee*, January 9.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Legislative Bulletin No. 1—Public Health League of California

The 55th session of the California Legislature convened at noon on Monday, January 4, 1943. Assemblyman Charles W. Lyon of Los Angeles was elected Speaker of the Assembly and Assemblyman Thomas A. Maloney of San Francisco was elected Speaker Pro Tempore. The Senate elected Senator Jerrold L. Seawell of Roseville as President Pro Tempore. Lieutenant-Governor Frederick F. Houser is president of the Senate.

Predictions are for a short session of the Legislature, as compared with those of recent years, but some of the veterans are wondering if actual adjournment will be reached before the early summer.

Although the general theme is to the effect that only legislation concerned with prosecution of the war effort will be considered, it is to be expected that many of the old issues that have confronted us in the past may be resurrected with an effort to tie them in with the war program. Constant vigilance is necessary.

605 Bills Introduced

As of this date (January 16, 1943), 605 bills have been introduced—213 in the Senate and 392 in the Assembly. No legislation sponsored by ethical medicine or dentistry has been introduced to date. A series of eight bills sponsored by the Association of California Hospitals have been introduced and assigned to committees for hearing when the second session of the Legislature convenes.

Committees

Principal interest to date has been in the make-up of the committees of the two houses. The Assembly has streamlined its organization and there is no longer a Committee on Medical and Dental Laws and a Committtee on Hospitals and Asylums. All committees dealing with health legislation have been combined into the Public Health Committee consisting of 23 members.

Personnel of the committees of particular interest to members of the League follows:

Assembly Committee on Public Health
(23 Members)
(D—Democrat) (R—Republican)

Chairman, Franklin J. Potter (R), Attorney, Hollywood
Vice-Chairman, Ernest E. Debs (D), Tax Statistician, Los Angeles
Edward J. Carey (R), Insurance Broker, Emeryville
Sam L. Collins (R), Attorney, Fullerton
Earl D. Desmond (D), Attorney, Sacramento
Ralph C. Dills (D), Teacher, Compton
C. Don Field (R), Trucking Contractor, Glendale
Edward M. Gaffney (D), Insurance, San Francisco
Chester F. Gannon (R), Attorney, Sacramento
Augustus F. Hawkins (D), Businessman, Los Angeles
John B. Knight (R), Businessman, Los Angeles
Frederick H. Kraft (R), Druggist, San Diego
Jacob M. Leonard (R), Commercial Secy., Hollister
Jack Massion (D), Druggist, Los Angeles
Richard H. McCollister (R), Insurance Broker, Mill Valley
Raup Miller (R), Insurance, Palo Alto
Kathryn T. Niehouse (R), San Diego
Edward F. O'Day (D), Attorney, San Francisco
John B. Pelletier (D), Research, Los Angeles
Lothrop Smith (R), Attorney, Alhambra
John F. Thompson (D), Farmer, San Jose
James E. Thorp (R), Farmer, Lockeford
Frank J. Waters (R), Attorney, Los Angeles

Senate Committee on Business and Professions
(9 Members)

Chairman, John F. Sheeley (D), Labor Executive, San Francisco
Vice-Chairman, H. R. Judah (R), Civic Auditorium Manager, Santa Cruz
Ed Fletcher (R), Land and Water Development, San Diego
James J. McBride (D), Insurance, Ventura
John Harold Swan (D), Junior College Teacher, Sacramento
Hugh M. Burns (D), Funeral Director, Fresno
George J. Hatfield (R), Farmer, Newman
R. R. Cunningham (D), Real Estate, Insurance, Hanford
H. E. Dillinger (D), Merchant, Placerville

Senate Committee on Public Health and Safety
(9 Members)

Chairman, Thomas F. Keating (D), Attorney, San Rafael
Frank L. Gordon (R), Farmer, Suisun
George M. Biggar (R), Farmer, Covelo
Oliver J. Carter (D), Lawyer, Redding
Hugh P. Donnelly (D), Insurance, Turlock
H. E. Dillinger (D), Merchant, Placerville
Hugh M. Burns (D), Funeral Director, Fresno
Chris N. Jespersen (R), Farmer, Atascadero
Randolph Collier (R), Title Business, Yreka

Your League has again established an office in the Hotel Sacramento, where the Executive Secretary, Ben H. Head, can be reached at all times.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

For address of California Public Health League, see adv. page 5.

California Legislature

55th Session: Report on Bills Introduced
(A—Assembly Bill; S—Senate Bill)

The following is a partial list of proposed statutes introduced prior to the February recess of the California Legislature:

S. 81 and A. 186 propose to amend the sales tax by exempting therefrom the sale of medicines sold as dietary supplements or adjuncts.

A. 6 proposes to amend the osteopathic practice act by eliminating the existing requirement that osteopaths, at the time of the annual renewal of their licenses, present satisfactory evidence of the completion, during the preceding year, of a minimum of thirty hours of professional educational work as approved by the osteopathic board.

A. 44 proposes to amend the Revenue and Taxation Code by exempting from the sales tax medicines or drugs, defined to include any substance or mixture of substances intended to be used internally or externally in the diagnosis, cure, treatment or prevention of diseases of man.

A. 80 proposes to amend the Revenue and Taxation Code so as to include the sales of medicines used as dietary supplements or adjuncts.

A. 129 proposes to amend the Revenue and Taxation Code by exempting from the sales tax the sale of medicines and drugs used in the diagnosis, cure, mitigation, treatment or prevention of disease in man, but not including any instrument or apparatus.

A. 152 proposes the appropriation of $2,000,000 to the regents of the University of California to be expended for the erection and equipment of a hospital to be maintained and supported by the regents in conjunction with the medical school of the University of California.

A. 227 proposes to amend the law relative to the liability of innkeepers so as to include hospitals by providing that a hospital shall be liable for losses of or injuries to personal property belonging to patients to the same degree as would a depositary for hire and providing further that if the hospital keeps a fireproof safe and notifies the patient to that effect then it is not liable for loss or damage to the personal property of a patient except so far as the acts of the hospital contribute thereto.

A. 230 proposes to authorize payments, out of the general funds of a city, city and county, or county, of a physician's fee for issuing a food certificate to any person needing more than the ration thereof might provide.

A. 292 proposes to amend the State labor code by prohibiting an employer or insurance company writing compensation insurance from contracting with any physician,

hospital or other person for the medical or surgical care or hospitalization of any injured person on the basis of such physician, hospital or other person receiving a percentage of the gross premiums collected by such insurance company or on the basis of any percentage of such employer's payroll or on the basis of any fixed charges which are less than the reasonable value of such services as fixed by rates adopted by the industrial accident commission. The bill would further prohibit a physician, hospital or other person from paying over to an employer or insurance carrier any rebate for sums received for the medical or surgical care or hospitalization of any injured employee.

A. 326 proposes to amend the Business and Professions Code relating to the practice of nursing by exempting therefrom the performance of certain services in case of an individual emergency and during a national emergency arising out of war or during an epidemic or other public disaster.

A. 327 proposes to amend the health and safety code regulating the licensing of clinics, dispensaries and maternity hospitals by exempting from such regulation a hospital corporation organized and operated exclusively for charitable purposes.

A. 328 proposes an amendment to the civil code which would create a lien in favor of doctors and hospitals for reasonable charges for hospital care, treatment and maintenance of an injured person, including drugs, supplies and x-ray and laboratory services, on any recovery of any sum had or collected by such injured person whether by judgment or by settlement, not to exceed, however, 50 per cent of such recovery. The proposal then sets forth certain notice requirements which the hospital or physician must give and provides a penalty against any person making payment or settlement of a claim without paying the amount covered by the lien. These provisions would not be applicable to claims arising under the workmen's compensation act, claims for wrongful death or negligent injury to a minor or claims for wrongful death to an adult or minor leaving a husband, wife or children.

A. 329 proposes to amend the law relating to medical and hospital care to indigents by prohibiting the board of supervisors from letting the care, maintenance or attendance of such indigent sick or dependent poor by contract to any person, except that in cases of unusual difficulty or which require treatment or the use of facilities not immediately available in the county and in cases of emergency the board may secure by contract hospital care within or without the county, including medical, surgical, x-ray, laboratory, nursing and general hospital service at a cost not exceeding the fair and reasonable value thereof, in either a private or a State supported institution.

A. 334 proposes to amend the Business and Professions Code relating to the practice of chiropody by redefining chiropody to mean the diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of the human foot and leg. The "and leg" is new and is substituted for the words "including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the feet."

A. 335 proposes to amend the health and safety code by including a chiropodist in the class of persons who may purchase hypodermic syringes or hypodermic needles or may sign an authorization for such purpose.—*J.A.M.A.*, Vol. 121, No. 5.

California Solons Take Recess Until March 8

Sacramento, Feb. 1.—(INS.)—Legislators today began a 36-day recess, following a 27-day history-making January session of the California Legislature which saw lawmakers enact many emergency measures and grant Governor Earl Warren broad wartime powers.

As the gavel fell on the first part of the fifty-fifth session yesterday and recessing the Legislature until March 8th, legislators had introduced 3,000 bills plus scores of resolutions and proposed constitutional amendments.

Fewer Measures

Although the 3,000 mark was higher than expected, it was still short of the 4,000 bills presented to the Legislature two years ago.

Sandwiched between the regular January session was a special session which enacted the administration's War Powers Act, completely reorganizing civilian defense and creating a 14 member State war council to direct civilian defense activities. . . . —San Francisco *Examiner*, February 2.

Concerning Proposed Amendments to Medical Practice Acts, Permitting Temporary Licensure*

In the January issue of California and Western Medicine, on pages 2 and 36, appeared comment concerning proposed legislation designed to amend Medical Practice Acts. Of interest, in connection therewith, is the letter which follows, wherein the point of view of the Oklahoma Board of Medical Examiners is expressed.

(copy)

Oklahoma Board of Medical Examiners
December 19, 1942.

Walter L. Bierring, M. D., Secretary,
Federation of State Medical Boards
of the United States,
406 Sixth Avenue,
Des Moines, Iowa.

Dear Doctor:

This will acknowledge your letter of December 10, 1942, together with enclosures of Proposed Legislation to Authorize and Provide for the Temporary Admission of Practice in this State [Oklahoma] of Physicians and Dentists to Protect the Health of the Civilian Population During the War Emergency Period, also Statement of Principles to be Recommended to the respective State Boards, etc. You are advised that at the regular meeting of the Oklahoma State Board of Medical Examiners, after a full and free discussion of this matter, it was the unanimous opinion of the Board that we are not in accord with findings of the Committee, and do not concur in proposed legislation for the following reasons:

1. We have had some experience with these so-called temporary permits. They are very easy to issue, but very difficult to revoke or terminate, and sometimes easy to transfer.

2. In order to comply with this idea, it would be necessary to completely amend our present laws of Oklahoma, which we think might be extremely dangerous to the profession. Amendments could and would be made not germane to the subject, as amendments would be introduced by radical interest that the Oklahoma State Medical Association has fought for years. We are of the opinion that it would only lower the standards we have been years building up.

3. Oklahoma has no direct reciprocity with any State. Reciprocity is within the discretion of the Board. We reserve the right to reciprocate with those States whose credentials equal or exceed those of Oklahoma, and the Board is sole judge of said credentials.

4. We do not believe it possible to issue a permit to practice in this State and confine the licentiate to a particular area. We have also had experience in this matter.

5. Our board is self-supporting through fees collected from examination, reciprocity, endorsements and annual registration, no legislative appropriation being made. It would, therefore, require a special appropriation by the legislature, which would be necessary to defray expenses of the Board. We feel that the legislature would be unwilling to do this. We would not agree to Section 7 in proposed statement of principles.

6. We do not believe there is an actual shortage of physicians or dentists in Oklahoma, and we know of no one actually suffering due to a supposed shortage of physicians.

7. We do not believe it is just or fair to those already in the service to pass this proposed legislation.

8. The Oklahoma State Board of Medical Examiners has requested that your office furnish us with the names of the members of the Committee of the Federation of State Medical Boards and of the Procurement and

* For editorial reference, see page 58.

Assignment Service present at meeting, as well as the States which they represented, held in Washington, D. C., December 6, 1942.

Yours very truly,
JAMES D. OSBORN, M. D., *Secretary, Oklahoma State Board of Medical Examiners, and President of Oklahoma State Medical Association.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Statement by Judge M. C. Sloss, Vice-President, Board of Trustees, Stanford University

Dr. Donald Bertrand Tresidder, a Stanford graduate with the degrees of A. B. and M. D., was elected on January 21, 1943, by the Board of Trustees as president of the University.

Dr. Tresidder was graduated from Stanford in 1919, and from Stanford Medical School in 1927, having been a teaching assistant in anatomy and physiology. He was elected to the Board of Trustees in December, 1939, and as president of the Board in May, 1942. He was the youngest member of the Board. For more than twenty years he has been closely identified with the educational and administrative policies of the University. He is president of the Yosemite Park and Curry Company.



Donald B. Tresidder, M. D.
President-Elect, Stanford University

He succeeds Dr. Ray Lyman Wilbur, who became president of the University January 1, 1916, and since June, 1941, has been its chancellor and acting president. Dr. Wilbur continues as acting president until the end of the present academic year and then as chancellor, to which position he was elected for life tenure.

Search for a new president of the University was undertaken by a joint committee of the trustees and faculty appointed in 1940, and many possibilities were considered. In December, while Dr. Tresidder was in the East interviewing a list of scholars on behalf of the Trustees, the ten heads of the schools, composing the University, prepared and submitted a petition to the Board recommending Dr. Tresidder's election as president. Dr. Tresidder in his contacts with the faculty members had impressed them deeply with his insight into academic problems and his ideals for a university of high degree. Several of the deans were members of an advisory faculty committee which had already reviewed many candidates for the position. After final review and consideration of the entire situation, the members of the Board of Trustees were unanimous in their selection. Dr. Tresidder resigned as a member of the Board since, under the Founding Grant, the president cannot be a member of the Board.



Chancellor Ray Lyman Wilbur, M. D.
Acting President, Stanford University

For the second time in the history of Stanford University, a doctor of medicine has been elected president of the University by action of the Board of Trustees.

He is Dr. Donald Bertrand Tresidder, who, though a qualified M. D., has spent the greater part of his life in the development of Yosemite National Park and in identifying himself closely with the educational and administrative policies of Stanford University. He succeeds Chancellor Ray Lyman Wilbur, also a doctor.

At the age of 49, Dr. Tresidder will reach the peak of a Stanford career which began in 1915 when, as an undergraduate, he worked for his board and room by cooking for a professor of the University.

The head of Stanford will assume his new position on September 1, 1943. He is now president of the Yosemite Park and Curry Company, a position he has held since 1925. He resigned presidency of the Stanford Board of Trustees to accept the university position. Dr. Ray Lyman Wilbur, widely-known president of Stanford University for more than 25 years, reached the retirement age in 1941 when he was appointed chancellor and agreed to serve as acting president until a successor had been chosen.

Dr. Tresidder in his contacts with the faculty members has impressed them deeply with his insight into academic problems and his ideals for a university of superlative quality. In December, the ten heads composing the university prepared and submitted a petition to the Trustees recommending Dr. Tresidder's election as president. Search for a new president was first undertaken in 1940 and many possibilities had been considered.

In accepting the presidency, Dr. Tresidder said:

"The leadership of a distinguished, independent, gift-supported university in these critical times presents both a compelling challenge and heavy responsibilities. I believe implicitly in the future of Stanford as it continues

to serve the living needs of people through education and research, and as it measures up fully to its responsibilities.

"However long the struggle or severe the dislocations arising out of the war, Stanford will maintain a focus where clear, realistic thinking is combined with a fresh, sturdy idealism—where tolerance, respect for the culture of other races and true understanding of the art of living form the cornerstone of a man's education—be he a future scientist, technician, business man or statesman."

Dr. Wilbur Lauds Dr. Tresidder, New President of Stanford

Following election of Dr. Donald B. Tresidder to the presidency of Stanford University, Dr. Ray Lyman Wilbur, acting president, issued the following statement:

"There is an old story about those who sought treasure afar and were surprised upon their return home to find what they were looking for in their own garden. A long search for a new president for Stanford University ends with the selection of one of our most beloved alumni, a Stanford man through and through. Dr. Donald Bertrand Tresidder has a fine mind, a fine spirit, and an appreciation of the true values of higher education. He believes in the privately endowed and privately supported university as of vital importance in our republic.

"Dr. Tressider will go on where some of the rest of us leave off, with the confidence of all and with a sense of public responsibility that will make him an American leader as well as an exceptionally able administrator."—San Francisco *News*, January 22.

COMMITTEE ON SCIENTIFIC WORK

Annual Session—Hotel Biltmore, Los Angeles

Sunday, May 2—Monday, May 3, 1943

California and Western Medicine, in its January issue, on pages 32-34 presented preliminary information concerning transportation and hotel facilities. The coming, two-day streamlined session received editorial mention in the December number, on page 341. The component county societies have also received communications in regard to the forthcoming session.

Section officers, whose names appear in each issue on adv. page 6, are at work on their respective programs and invite correspondence from prospective essayists.

Members who may question the advisability of an annual session in 1943, should find recent editorial comment in the *New York State Journal of Medicine* to be of interest. Insertion of California for New York, and Los Angeles for Buffalo, would make the remarks equally applicable to the 72nd annual session of the California Medical Association which will close its session on Monday, May 3rd, the day on which New York will hold its first meetings. Quotation follows:

The 1943 Annual Meeting of the Medical Society of the State of New York will be held in Buffalo, May 3-6, 1943, at the Hotel Statler. It will be the second such meeting in wartime and should be attended by all who can possibly be there; yes, and even by those who for some reason think they can't! We know it will be difficult—use of cars restricted, train travel onerous, bicycles rationed, too far to walk, limited hitching and stable facilities for horses, too expensive to fly, canal boats and barges not running on regular schedules. Conditions were worse in grandfather's day, but he came in large numbers, and so will you.

Much has happened since we met in New York last spring, much that you will want to hear about: war medicine and surgery, new treatments, new instruments, changes in methods of practice, what the profession in various parts of the State and elsewhere is doing and planning to meet its particular needs. Invitations to attend have been sent to the membership of the societies of neighboring States so that for the first time this year you will have the opportunity to meet those of our neighbors who can come. In a way, it promises to be rather a regional meeting, for some of the adjacent States have canceled their meetings or planned them at a different time of year or are holding them too far away. So you will see men and women from Pennsylvania, Ohio, Michigan, New Jersey, and possibly even Canada, as well as from the Empire State.

Make your plans now to come. Later we shall tell you more of the scientific program, but just now we ask you to note the dates and to lay your plans to come. Buffalo, May 3-6, 1943—write it down *now* in your engagement book, then watch the *Journal* for further announcements.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Nurses' Pay Raise Sought by Hospitals

Scores of California hospitals are seeking governmental approval of an upward adjustment of staff nurses' salaries in line with standards established by the California State Nurses' Association, officers of the group said yesterday.

Some 90 per cent of the State's hospitals, the officers said, have so far agreed to the increases, which are subject to War Labor Board sanction.

Proposed standards call for a minimum entrance salary of $140 a month, without maintenance, for a graduate nurse, with tenure of service boosts at the rate of $2.50 every six months up to $155 a month.

Hospital applications for Government approval are being sent directly to Dr. Paul A. Dodd.* University of California, at Los Angeles, a member of the N.W.L.B. panel, for combined action. Prompt submission of these voluntary applications was urged.

Organized nursing has advised the hospital group that a health crisis in California, with so many nurses joining the armed forces, could result from delay in adjusting salaries to lure new candidates into the field. It was explained that nurses' salaries have not been advanced in recent years to keep pace with the rising cost of living.—San Francisco *Chronicle*, December 27.

Industrial workers are as much a part of an all-out war effort as are the men in uniform, since twelve men are needed in the factory to keep one man in the field and loss of working time is as serious as the loss of a battle. Tuberculosis is two and a half times as great in industry as in the general population. It thus becomes the serious responsibility of the industrial medical officer to protect such workers by case-finding surveys, and the control of tuberculosis is an important phase of industrial hygiene.—G. J. Wherrett, M. D., *Canadian Pub. Health Jour.*, Sept., 1942.

* Paul A. Dodd, Ph.D. will be remembered as the director who gathered the statistics and later wrote a book dealing with the "Medical-Economic Survey of California."

COMMITTEE ON MEDICAL ECONOMICS

Income Taxes: 1943*

Millions of individuals will be called upon early next year to pay income taxes for the first time. Present taxpayers may find their taxes two to four times the amount paid this year. Few people appreciate how heavy a tax burden has been placed upon the average family budget.

The new wartime rates recently enacted by Congress apply to all of 1942. Ten months of the year have already gone by. This is to urge upon all present and prospective taxpayers the importance of

1. Making plans NOW to meet the heavy taxes payable at the end of this year, and

2. Keeping adequate records from which to compute those taxes. . . .

Beginning January 1, an additional "Victory tax" of 5 per cent will go into effect. Wage and salary earners will have it deducted from their pay checks. It applies to all income over $624 a year plus certain specified deductions. Part of the Victory tax is to be returned after the war, unless the taxpayer chooses to use this post-war credit currently in the purchase of government bonds, payment of life insurance premiums, or retiring indebtedness.

With taxes of this magnitude and complexity, it is imperative that individuals keep records which will enable them to prepare returns and take advantage of all deductions and credits permitted by law. . . .

Under the community property law of California a husband and wife share ownership in the family income on a 50/50 basis, except that from the separate property of one spouse. Because of this split ownership. married couples whose total taxable income exceeds $2,000 may reduce their surtaxes by filing separate returns.

The above is directed primarily to individuals. It is equally important that business concerns inform themselves promptly about the taxes due on 1942 business. New individual tax rates range as high as 88 per cent; corporate normal and surtaxes as high as 40 per cent. The corporate excess profits tax is 90 per cent. The very soundness of a business enterprise may be jeopardized through failure to understand and meet the tax problem.

The Physician's Federal Income Tax—1943

Prepared by the A.M.A. Bureau of Legal Medicine and Legislation

The Revenue Act of 1942 has been correctly described as the greatest revenue raising measure in the history of our country and finds its justification in the tremendous needs of our war program, needs having to do with the actual expenditures for war purposes plus needs in relation to inflation potentialities. The act not only will spiral the tax burden of prior taxpayers but will bring into the income tax picture many millions of persons whose low income has heretofore constituted exempt income. Already plans are under way for additional legislation to raise still more revenue, and the tax burden may reasonably be expected to assume even greater proportions.

During the time when the new act was being formulated by congressional committees and when it was being discussed first in the House and in the Senate, advocates of the so-called Ruml pay-as-you-go plan for the payment of individual income taxes persistently suggested the undesirability of a continuation of the existing practice of taxing during a succeeding year the income received by an individual during a preceding year. There has recently been renewed interest in this plan, and the possibility is not remote that a changed policy may be adopted in the reasonably near future, perhaps by March 15. The President, the Treasury Department and leaders in the Congress have openly espoused the theory of the pay-as-you-go plan, and this espousal has given rise to some doubt on the part of taxpayers concerning the filing of returns this year. The doubt has been apparently so widespread as to call for a public statement by the chairman of the House Committee on Ways and Means, the committee that will initiate any change in our tax procedures, advising taxpayers that a return must be filed on or before March 15 and that that return must be based on the provisions of the 1942 Revenue Act. Despite the uncertainties of the future as to the pay-as-you-go matter, therefore, it is essential that the broad requirements of the new act be fully understood by federal income tax payers.

The Revenue Act of 1942 reduces the personal exemptions of single persons from $750 to $500 and of married persons or heads of families from $1,500 to $1,200. It reduces the credit for dependents from $400 to $350. An additional exemption is allowed members of the armed forces below the grade of commissioned officers. If a serviceman is single, then the first $250 of the service pay he received during 1942 is exempt. If he is married or the head of a family, then the first $300 is exempt. The determination of a taxpayer's status in the armed forces and his family status will be made as of the end of the taxable year for the purpose of this particular exemption.

The basic rate of taxation is increased from 4 per cent to 6 per cent. The surtax rate is elevated from 6 per cent on the first $2,000 of surtax net income to 13 per cent, with a constant increase in rates for incomes in the higher brackets. The earned income credit of 10 per cent remains as heretofore. This credit may be claimed in connection with the normal tax but not with the surtax.

The act continues the provision for a simplified tax schedule for use by taxpayers having gross incomes of $3,000 or less, derived wholly from salaries, wages or other forms of compensation for personal services, dividends, interest, rents, annuities or royalties. The use of the simplified form remains optional. If the taxpayer has no deductions, it will, generally speaking, be to his advantage to use this form. If he has deductions he should tentatively figure the tax under both the regular method and the optional method and use whichever method happens to be to his advantage.

Returns under the new act need not be made under oath, as has been the requirement heretofore. This will relieve taxpayers of the petty annoyance of having their returns sworn to before a notary public or some other official authorized to administer oaths. The taxpayer, however, who falsifies a return will be subject to heavy penalties even though he is not required to execute the return under oath.

Who Must File Returns

In General.—1. Returns must be filed by every unmarried person and by every married person not living with spouse, if fross income during 1942 was $500 or more.

2. Returns must be filed by every married person who lived with spouse, if gross income during 1942 was $1,200 or over. If both husband and wife had income and their combined gross income was $1 200 or over, they must either file separate returns or, if both are citizens, or residents of the United States and if they were living together at the end of the taxable year, they may file a

* Bulletin of the Los Angeles Chamber of Commerce.

joint return. If a person was married and lived with spouse for only part of 1942, special rules apply with respect to the filing of returns, and physicians who come within this classification should read carefully the instructions given on the tax return blanks.

If the status of a taxpayer, so far as it affects the personal exemption or credit for dependents, changed during the year, the personal exemption and credit must be apportioned, under rules and regulations prescribed by the Commissioner of Internal Revenue with the approval of the Secretary of the Treasury, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month should be disregarded unless it amounts to more than half a month, in which case it is to be considered as a month.

Physicians in Military or Naval Service.—The fact that a physician may be in service does not of itself excuse a failure to file a return, for the income tax act applies to persons in service as well as to persons engaged in civilian activities. Physicians who have gone into service, therefore, should if at all possible, file complete returns before the deadline. While, unfortunately, definite regulations have not been issued to cover the situation, it is understood that, if because of the inaccessibility of necessary records a physician in service is unable to file a complete return, he may file a tentative return on which he must estimate his income, deductions and tax as best he can and indicate on the return his reasons for following this procedure. He will be required at a later date to file a complete return, and necessary adjustments in the tax will be made.

If a physician in service is on duty outside the United States no income tax return or payment of any income tax will become due, generally speaking, until the fifteenth day of the third month following the month in which the physician ceases (except by reason of death or incompetency) to be a member of the military forces on sea duty or in service outside the continental United States, or the fifteenth day of the third month following the month in which the present war is terminated as proclaimed by the President, whichever may be the earlier.

Gross and Net Incomes: What They Are

Gross Income.—A physician's gross income is the total amount of money received by him during the year for professional services, regardless of the time when the services were rendered for which the money was paid, assuming that the return is made on a cash receipts and disbursements basis, plus such money as he has received as profits from investments and speculation and as compensation and profits from other sources.

If a physician receives a salary as compensation for services rendered and in addition thereto living quarters or meals, the value to the physician of the quarters and meals so furnished ordinarily constitutes income subject to tax. If, however, living quarters or meals are furnished for the convenience of the employer, the value thereof need not be computed and added to the compensation otherwise received by the physician. As a general rule, the test of "convenience of the employer" is satisfied if living quarters or meals are furnished to a physician who is required to accept such quarters and meals in order to perform properly his duties. For example, if a physician employed by a hospital is subject to immediate service at any time during the twenty-four hours of the day and therefore cannot obtain quarters or meals elsewhere without material interference with his duties and on that account is required by the hospital to accept the quarters or meals furnished by it, the value thereof need not be included in the gross income of the physician.

Net Income.—Certain professional expenses and the expenses of carrying on any enterprise in which the physician may be engaged for gain may be subtracted as "deductions" from the gross income, to determine the net income on which the tax is to be paid. An "exemption" is allowed, the amount depending on the taxpayer's marital status during the tax year as stated before. These matters are fully covered in the instructions on the tax return blanks.

Earned Income.—In computing the normal tax, but not the surtax, there may be subtracted from net income from all sources an amount equal to 10 per cent of the earned net income, except that the amount so subtracted shall in no case exceed 10 per cent of the net income from all sources. Earned income means professional fees, salaries and wages received as compensation for personal services, as distinguished from receipts from other sources.

The first $3,000 of a physician's net income from all sources may be regarded under the law as earned net income, whether it was or was not in fact earned within the meaning set forth in the preceding paragraph. Net income in excess of $3,000 may not be claimed as earned unless it in fact comes within that category. No physician may claim as earned net income any income in excess of $14,000.

Physicians in Military or Naval Service

As previously pointed out, physicians in service are as much subject to the income tax law as are physicians engaged in civilian practice. The service pay of such physicians must be reported as income. Commutation of quarters and rental value of quarters occupied by medical officers, however, are not taxable income.

If the ability of physicians in service to pay income taxes is materially affected by such service, payment of the tax falling due before or during the service may be deferred for a period extending not more than six months after termination of service. This deferment is authorized by section 513 of the Soldiers' and Sailors' Civil Relief Act of 1940 and applies to all members of the Army, Navy, Marine Corps and Coast Guard, and to all officers of the United States Public Health Service detailed by proper authority for duty either with the Army or Navy, on active duty or undergoing training or education under the supervision of the United States preliminary to induction into service. This does not apply to the tax imposed on employers by section 1400 of the Federal Insurance Contributions Act. This deferment is not automatic. The taxpayer must present evidence to show that his ability to pay the tax is materially impaired by reason of military service. Proof of that impairment should be submitted at the time the tax is due, on a form procurable from the offices of the collectors of internal revenue. A copy of the form was reproduced in the February 28, 1942 issue of the *Journal* on page 737.

The Victory Tax

The physician need give no consideration to the new 5 per cent Victory tax in making his return on or before March 15. As explained in the *Journal*, December 5, 1942, this tax does not apply to income received during 1942, although physicians who are classifiable as employees will periodically have the tax withheld from their salaries during 1943.

Taxation of Accounts Receivable

The Revenue Act of 1942 remedies an unjust method of taxation that has heretofore prevailed in connection with the unpaid accounts on the books of a taxpayer at the time of his death. Under prior law, for the year of death, the value of such accounts has been included as income and subject to the income tax rates, even though

the taxpayer actually received no income at all therefrom. Hereafter the value of the unpaid accounts will not be considered as a part of the income of the decedent for the year of death but will be taxable when paid, as a part of the income of the person receiving the money. A detailed discussion of this matter was published in the *Journal,* January 10, 1942, page 149.

Deductions for Professional Expenses

A physician is entitled to deduct all current expenses necessary in carrying on his practice. The taxpayer should make no claim for the deduction of expenses unless he is prepared to prove the expenditure by competent evidence. So far as practicable, accurate itemized records should be kept of expenses and substantiating evidence should be carefully preserved. The following statement shows what such deductible expenses are and how they are to be computed:

Office Rent.—Office rent is deductible. If a physician rents an office for professional purposes alone, the entire rent may be deducted. If he rents a building or apartment for use as a residence as well as for office purposes, he may deduct a part of the rental fairly proportionate to the amount of space used for professional purposes. If the physician occasionally sees a patient in such dwelling house or apartment, he may not, however, deduct any part of the rent of such house or apartment as professional expense; to entitle him to such a deduction he must have an office there, with regular office hours. If a physician owns the building in which his office is located, he cannot charge himself with "rent" and deduct the amount so charged.

Office Maintenance.—Expenditures for office maintenance, as for heating, lighting, telephone service and the services of attendants are deductible.

Supplies.—Payment for supplies for professional use are deductible. Supplies may be fairly described as articles consumed in the using; for instance, dressings, clinical thermometers, drugs and chemicals. Professional journals may be classified as supplies and the subscription price deducted. Amounts currently expended for books, furniture and professional instruments and equipment, "the useful life of which is short," generally less than one year, may be deducted; but if such articles have a more or less permanent value, their purchase price is a capital expenditure and is not deductible.

Equipment.—Equipment comprises property of a more or less permanent nature. It may ultimately wear out, deteriorate or become obsolete, but it is not in the ordinary sense of the word "consumed in the using."

The cost of equipment such as has been described, for professional use, cannot be deducted as expense in the year acquired. Examples of this class of property are automobiles, office furniture, medical, surgical and laboratory equipment of more or less permanent nature, and instruments and appliances constituting a part of the physician's professional outfit, to be used over a considerable period of time, generally over one year. Books of more or less permanent nature are regarded as equipment and the purchase price is therefore not deductible.

Although the cost of such equipment is not deductible in the year acquired, nevertheless it may be recovered through depreciation deductions taken year by year over its useful life, as described later.

No hard and fast rule can be laid down as to what part of the cost of equipment is deductible each year as depreciation. The amount depends to some extent on the nature of the property and on the extent and character of its use. The length of its useful life should be the primary consideratiton. The most that can be done is to suggest certain average or normal rates of depreciation for each of several classes of articles and to leave to the taxpayer the modification of the suggested rates as the circumstances of his particular case may dictate. As fair, normal or average rates of depreciation, the following have been suggested: automobiles, 25 per cent a year; ordinary medical libraries, x-ray equipment, physical therapy equipment, electrical sterilizers, surgical instruments and diagnostic apparatus, 10 per cent a year; office furniture, 5 per cent a year.

The principle governing the determination of all rates of depreciation is that the total amount claimed by the taxpayer as depreciation during the life of the article, plus the salvage of the article at the end of its useful life, shall not be greater than its purchase price or, if purchased before March, 1913, either its fair market value as of that date or its original cost, whichever may be greater. The physician must in good faith use his best judgment and claim only such allowance for depreciation as the facts justify. The estimate of useful life, on which the rate of depreciation is based, should be carefully considered in his individual case.

Medical Dues.—Dues paid to societies of a strictly professional character are deductible. Dues paid to social organizations, even though their membership is limited to physicians, are personal expenses and not deductible.

Postgraduate Study.—The Commissioner of Internal Revenue holds that the expense of postgraduate study is not deductible.

Traveling Expenses.—Traveling expenses, including amounts paid for transportation, meals and lodging, necessarily incurred in professional visits to patients and in attending medical meetings for a professional purpose, are deductible.

Automobiles.—Payment for an automobile is a payment for permanent equipment and is not deductible. The cost of operation and repair, and loss through depreciation, are deductible. The cost of operation and repair includes the cost of gasoline, oil, tires, insurance, repairs, garage rental (when the garage is not owned by the physician), chauffeurs' wages, and the like.

Deductible loss through depreciation of an automobile is the actual diminution in value resulting from obsolescence and use and from accidental injury against which the physician is not insured. If depreciation is computed on the basis of the average loss during a series of years, the series must extend over the entire estimated life of the car, not merely over the period in which the car is possessed by the present taxpayer.

If an automobile is used for professional and also for personal purposes—as when used by the physician partly for recreation, or so used by his family—only so much of the expense as arises out of the use for professional purposes may be deducted. A physician doing an exclusive office practice and using his car merely to go to and from his office cannot deduct depreciation or operating expenses; he is regarded as using his car for his personal convenience and not as a means of gaining a livelihood. What has been said in respect to automobiles applies with equal force to horses and vehicles and the equipment incident to their use.

Miscellaneous

Contributions to Charitable Organizations.—For detailed information with respect to the deductibility of charitable contributions generally, physicians should consult the official return blank or obtain information from the collectors of internal revenue or from other reliable sources. A physician may not, however, deduct as a charitable contribution the value of services rendered an organization operated for charitable purposes.

Bad Debts.—Physicians who make their returns on a cash receipts and disbursements basis, as most physicians do, cannot claim deductions for bad debts.

Taxes.—Taxes generally, either federal or state, are deductible by the person on whom they are imposed by

law. Both real and personal property taxes are deductible; but so-called taxes, more properly assessments, paid for local benefits, such as street, sidewalk, and other like improvements, imposed because of and measured by some benefit inuring directly to the property against which the assessment is levied, do not constitute an allowable deduction from gross income. Physicians may deduct State gasoline taxes and State sales taxes. In some States sales taxes are imposed on the seller, but, if they are passed on to the buyer, the latter may deduct them.

State income and use taxes are deductible; Federal income taxes are not. Among the Federal taxes that a physician may deduct are those on admissions, dues, initiation fees, safety deposit boxes, tax on telegraph, telephone, cable and radio messages, and the Federal use tax on automobiles. State automobile license fees are deductible. If a State or local fee is imposed for regulatory purposes, and not to raise revenue, the fee may not ordinarily be deducted as a tax. If such fees, however, are classifiable as a business expense, they are deductible as such. Annual registration fees imposed on physicians probably come within the category of regulatory fees and should be deducted as a business expense rather than as taxes. Local and State occupational taxes imposed on physicians are deductible either as taxes or as a business expense, depending on the purpose for which the tax is imposed.

The excise taxes imposed on employers by section 804, title VIII, and section 901, title IX, of the Social Security Act, commonly referred to as old age and unemployment benefit taxes, are deductible annually by employers in computing net income for Federal income tax purposes. If the taxpayer's return is made on a cash basis, as are the returns of practically all physicians, the taxes are deductible for the year in which they are actually paid. If the return is made on an accrual basis, the taxes are deductible for the year in which they accrue, irrespective of when they are actually paid. Employees, including physicians whose employment brings them within that category, may not deduct the tax imposed on them by section 801, title VIII, of the Social Security Act, generally referred to as the old age benefits tax. If, however, the employer assumes payment of the employee's tax and does not withhold the amount of the tax from the employee's wages, the amount of the tax so assumed may be deducted by the employer, not as a tax but as an ordinary business expense.

Medical Expense.—A taxpayer may deduct amounts expended for medical, dental and hospital care, not compensated for by insurance or otherwise, including amounts paid for accident and health insurance, according to a prescribed formula. Deductions will be permitted to the extent that such expenses exceed 5 per cent of the net income of the taxpayer but not in excess of $2 500 in case of the head of a family, or $1,250 in case of other individual taxpayers.

Equipment Necessitated by Military Service.—The cost of equipment of an Army officer to the extent only that it is especially required for his profession and does not merely take the place of articles required in civilian life is deductible. The cost of a uniform is considered a personal expense and hence not deductible.

Laboratory Expenses.—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when under corresponding circumstances they would be deductible if they related to a physician's office.

Losses by Fire or Other Causes.—Loss of and damage to a physician's equipment by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of repair claimed as a deduction.

Insurance Premiums.—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

Expense in Defending Malpractice Suits.—Expense incurred in the defense of a suit for malpractice is deductible as a business expense.

Sale of Spectacles.—Oculists who furnish spectacles, etc., may charge as income money received from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should in such cases show charges for services separate and apart from charges for spectacles, etc.

Nontrade or Nonbusiness Expenses

A new provision in the Revenue Act of 1942, permits, in the case of an individual, the deduction of all the ordinary, necessary expenses paid or incurred during the taxable year for the production or collection of income, or for the management, conservation or maintenance of property held for the production of income. While the phraseology of this provision is very broad, the Commissioner of Internal Revenue has by regulation ruled that the following expenses, among others, are not deductible under it: Commuters' expenses; expenses of taking special courses of training; expenses in seeking employment or in placing one's self in a position to begin rendering personal services for compensation; bar examination fees and other expenses incurred in securing admission to the bar, and corresponding fees and expenses incurred by physicians, dentists, accountants and other taxpayers for securing the right to practice their respective professions.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (15)

Alameda County (2)

John A. Blosser, *Oakland*
H. Stewart Kimball, *Oakland*

San Diego County (4)

Laurl W. Moffitt, *San Diego*
Robert J. Prentiss, *San Diego*
Kathleen A. Riffle, *San Diego*
Ira H. Wilson, *Glasgow, Montana*

San Francisco County (8)

J. Prentiss Burtis, *San Francisco*
Thomas Philip Burton, *San Francisco*
John Sampson Chase, *San Francisco*
Richard Henry Creel, *San Francisco*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Gerald M. Feigen, *San Francisco*
Percy A. Millar, *San Francisco*
Meyer L. Mizel, *San Francisco*
Arthur D. Prentice, *San Francisco*
Santa Cruz County (1)
David Maeth, *Santa Cruz*

Transfers (1)

James G. Terry, from San Francisco County to Alameda County

In Memoriam

Beard, Edwin Abraham. Died at Inglewood, January 4, 1943, age 72. Graduate of the College of Physicians and Surgeons, Keokuk, Iowa, 1898. Licensed in California in 1924. Doctor Beard was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Collins, Asa Weston. Died at Redwood City, January 19, 1943, age 67. Graduate of Cooper Medical College, San Francisco, 1903. Licensed in California in 1903. Doctor Collins was a retired member of the San Francisco County Medical Society, and the California Medical Association.

✣

Detling, Frank Edward. Died at Los Angeles, December 25, 1942, age 67. Graduate of Northwestern University Medical School, Chicago, 1901. Licensed in California in 1901. Doctor Detling was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Dillon, Joseph, Jr., Lieutenant (s.g.) Died at sea, December 6, 1942, age 37. Graduate of Columbia University College of Physicians and Surgeons, New York City, 1932. Licensed in California in 1937. Doctor Dillon was a member of the Sacramento Society for Medical Improvement, and the California Medical Association.

✣

Hendricks, Francis Royal. Died at Ventura, December 27, 1942, age 45. Graduate of Jefferson Medical College of Philadelphia, Pennsylvania, 1924. Licensed in California in 1925. Doctor Hendricks was a member of the Ventura County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Kruse, Fred Herman. Died at San Francisco, January 14, 1943, age 64. Graduate of the University of California Medical School, 1915. Licensed in California in 1915. Doctor Kruse was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Noland, Clyde Amandee. Died at Long Beach, October 24, 1942, age 68. Graduate of the State University of Iowa College of Medicine, Iowa City, 1905. Licensed in California in 1929. Doctor Noland was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

Owen, Carl Shuey. Died at National City, October 18, 1942, age 65. Graduate of Northwestern University Medical School, Chicago, 1904. Licensed in California in 1906. Doctor Owen was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Quinan, Clarence. Died at Los Gatos, December 8, 1942, age 73. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1897. Licensed in California in 1897. Doctor Quinan was a member of the Placer-Nevada-Sierra County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Rosanoff, Aaron Joshua. Died at Beverly Hills, January 7, 1943, age 64. Graduate of Cornell University Medical College, New York, 1900. Licensed in California in 1922. Doctor Rosanoff was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and a Fellow of the American Medical Association.

✣

Shattinger, Charles. Died at Los Altos, December 13, 1942, age 77. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1886. Licensed in California in 1918. Doctor Shattinger was a retired member of the Santa Clara County Medical Society, and the California Medical Association.

✣

Shattuck, Hobart Parker. Died at Los Angeles, December 10, 1942, age 65. Graduate of Cornell University Medical College, New York, 1903. Licensed in California in 1911. Doctor Shattuck was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Stolle, Francis. Died at Dixon, December 19, 1942, age 54. Graduate of Stanford University School of Medicine, 1913. Licensed in California in 1913. Doctor Stolle was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

News Items

On Tuesday, January 12, Mrs. F. G. Lindemulder, State President, met with members, councilors and officers from the 6th and 7th Districts, at a round-table discussion and luncheon, held in the Women's Athletic Club

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

in San Francisco.

In speaking on the rôle of the Medical Auxiliary in war activities, Mrs. Edmond Morrissey, of San Francisco, laid particular emphasis on the Blood Bank. A dramatic interpretation of the History of the Red Cross was given by Mrs. Mary Waterstreet.

Alameda County's January meeting with luncheon was held at the Claremont Country Club. Dr. Robert J. Kerner, Sather Professor of Modern European History, spoke to the group. His topic was "On the Threshold of Victory." The program included a group of songs by Klara Kiefer, accompanied by Helen Berryhill Heilman. Hostesses for the day were Mrs. Roy Nelson and Mrs. Robert Glen.

The first Board meeting of the year was held by the San Francisco Auxiliary on Wednesday, January 5, at the Medical Society's headquarters on Washington Street. A detailed report on the recent Hospitality Day was given. Blood Bank Chairmen, from the various branches conducted by volunteers from the Auxiliary, gave reports.

Miss L. M. Messer, Superintendent of the Kindergarten Division from the State Teachers College, will speak on Nursery Schools at the regular meeting on January 19.

The November meeting of the Woman's Auxiliary to the Sacramento Medical Society was held at the home of Mrs. W. J. Van Den Berg.

During the evening winners in the Annual Public Speaking Contest were presented to the members. This contest is sponsored each year by the Auxiliary, and students from the two high schools of the city and the Junior College are eligible. Subjects of the winners were: "The Possible Dangers of Spreading Disease by Aeroplane," "What Shall We Do to Develop Physical Fitness in Our Youth?" "The Effect of Alcohol Upon Our Armed Forces," and the "Dangers of Self-Medication."

A social meeting was held at the home of Dr. and Mrs. Frederick Scatena on Tuesday evening, December 15, when a program of Christmas music and Christmas carols was enjoyed by the group.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (November)	35,000
Rural Health Program	3,500
War Housing Projects (January 1st) (Approximate)	32,000
Vallejo	10 000
Marin	5.000
Los Angeles	7.000
San Diego	10,000

There have been articles in various magazines and newspapers regarding the C.P.S. plan for medical care for war workers living in Federal Housing Projects. Some of these reports have been accurate, while others contained implications which have caused comment by physicians, laymen, government officials, etc. For the purpose of clarification, it is well to restate, first, C.P.S.'s reasons for entering into the war housing projects, and second, the method by which it operates.

The war housing projects have been constructed in areas surrounding large war industrial plants. These have centered around San Diego, Los Angeles and the San Francisco Bay Area. Large influxes of population have occurred to meet the manpower need of these rapidly growing industries. Many communities have doubled or trebled in population, and during the same period the need of the armed services has reduced the number of doctors available to serve even the original population. Therefore, it is not a question of the ability of the worker to pay for his medical bills, but a question of bringing medical service to him.

In order to do this, it was necessary to increase the doctor power in these areas. Very early it was shown that this could not be done by the voluntary movement of physicians from other locations. Doctors who had active practices in other areas could not afford to move to a new community, where their income would be very uncertain, and even if they were willing to relocate, in most instances they could not become effective immediately. It became evident, then, that there should be available capital to assist physicians to move without causing them financial hardships, and also any such proposal should provide means for making these doctors' skills effective immediately upon relocation. The C.P.S. plan was conceived on the basis of adequately financing this movement, and was only made possible by a working arrangement between the Federal Public Housing Authority and California Physicians' Service. This is where the terms "Built-in medical care" and "Medical care dues with the rent" originated.

Actually, what is transpiring is that the Federal Public Housing Authority acts as the agent of California Physicians' Service in collecting the dues. These dues are set separate from the rent, but are collected at the time a tenant pays his rent. This has simplified the procedure of billing and collecting, which constitutes a large part of overhead cost in other types of prepaid medical care plans.

Also, with the sponsorship and coöperation of the Housing Authority, a larger degree of participation of tenants is acquired, in many instances reaching close to 100 per cent of all of the residents. This puts C.P.S. in a more secure financial position, and will make it possible for us to pay physicians who render extended service on a basis of a higher unit value.

The whole subject of C.P.S.'s entering into war housing projects was carefully discussed and cleared with the Council of the California Medical Association. In each area where these programs are operating, the proposal was again discussed with the local physicians immediately concerned.

Through this C.P.S. plan, physicians who desire to relocate are adding to the community facilities by directly contributing to an essential war effort. The Housing Authority provides the quarters for these health centers in which these C.P.S. physicians may render their services. The physicians in the health center treat the general run of illnesses which occur, and refer the more complicated cases, such as surgery, consultations or cases requiring hospitalization, to professional members of California Physicians' Service who are carrying on private practice in the adjacent communities. In this way, the minor illnesses are handled on the project itself, thus relieving the worker and his family of the inconvenience of travel, and cutting down the loss of working time of

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

the worker himself.

Because the minor illnesses are taken care of in the medical center, the overburdened physician in private practice in the community is enabled to serve the normal population more adequately, and has more time available to take care of the severe illnesses which are referred to him from the medical center. This certainly would not be true if the entire responsibility for care of this new population were thrust upon him, with its attendant load of home calls and night calls. Not only is the conservation of the physician's time evident, but the public health aspects of the entire problem are considerably improved. It is perfectly evident that when ten to fifteen thousand people, gathered from all sections of the country, become residents in a compact housing unit, the danger of epidemics is extreme. Because of the availability of the physicians on the project, and the close working relationship of the medical service with the housing authority, these situations can be coped with immediately. Also, by the very availability of physicians and visiting nurses, the amount of disease caught in its early stages (thus preventing more serious complications from developing) contributes to cutting down the morbidity rate of illnesses which could result in loss of manpower.

These are some of the fundamental reasons for C.P.S. entering into this field of medical care, and for the method which has had to be adapted to the conditions.

Farmers' Health Group Will Be Organized Here

Fresno, Kings Ranchers Will Convene to Discuss New Medical Program

Organization of the State Center Farmers' Health Association, to provide a low cost medical program for farm families of Fresno and Kings Counties, will be undertaken at a meeting in the Hotel Fresno, Saturday, January 30th.

The organizing committee is headed by O. M. Davis, master of the Fresno Pomona Grange.

Worked out with the California Physicians' Service, representing 5,300 doctors in the State, the plan is designed to benefit farm families whose net income is $2,000 or less and whose income is at least 50 per cent derived from agriculture. Such families will be eligible for the health insurance at an annual cost ranging from $20 for single adults to a maximum of $60 for a family.

Already In Effect

The plan is being inaugurated here with the assistance of the Federal Security Administration. It is already in effect in many parts of the State.

Edgar H. File, district FSA rural rehabilitation supervisor, said the plan covers not only medical care but hospitalization as well. Persons subscribing to the service may select any physician belonging to the C.P.S., which includes a majority of the doctors in California.

Deadline Is Set

"All prospective members are asked to attend the organization meeting," File said. "The C.P.S. has set February 15th as the deadline for membership in the organization after which no new members will be accepted until February, 1944.

"A president and a board of directors will be elected at the meeting."

Meeting Begins at 8 P.M.

The meeting is scheduled for 8 P.M. Davis will preside.

Persons desiring information may contact Davis, through the grange; C. W. Simmons of the Fresno Production Credit Association, or File in Room 302, United States Courthouse and Postoffice, Fresno.—Fresno *Bee*, January 19.

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Vocational Rehabilitation.— S. 2714, introduced by Senator LaFollette of Wisconsin, August 13, and submitted to the Senate Committee on Education and Labor. A bill to provide for the vocational rehabilitation of individuals suffering from war-connected or other disabilities. A companion bill, H. R. 7484, introduced by Representative Barden, North Carolina. August 13, was submitted in the House Committee on Education.

Comment.—This bill is divided into three titles. Title I proposes to enact a War Disabled Vocational Rehabilitation Act. Title II proposes to amend and reënact an act to provide for the promotion of vocational rehabilitation of persons disabled in industry or otherwise and their return to civil employment, approved June 2, 1920, as amended, and to designate that act as the Coöperative Rehabilitation Training Act. Title III proposes the enactment of a Blind Vocational Rehabilitation Act. . . .

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1943.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In February, KFAC will present these broadcasts on the following Saturdays: February 6, 13, 20, and 27.

The Saturday broadcasts by KECA are given at 10:45 a.m., under the title, "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Journals:* How about more subscribing for South American medical periodicals? Get lists from consuls. Note the new XIIth *U. S. Pharmacopeia* (Easton, 1942), gives Spanish synonyms? Remember we're North Americans. Britain's Imperial Chemical Industries publishes interesting general science quarterly with appropriate name *"Endeavor,"* and with big name reviews. Academic Press (125 E. 23rd St., N. Y. C.), issues 2 vols. yearly at $5.50 per, the *Archives of Biochemistry.* Contains intriguing article by W. F. Petersen on Weather and Biochemical Variability (1:269 (Dec.), 1942. How's for seeing that coöperative society journals have broad geographic representation on editorial committees in order to prevent dominance by canons of self-justified ins? *Vale* and let's hope soon *Ave* to Francis Packard and the *Annals of Medical History,* suspending after 25 years! *Federation Proceedings* will be published even though the Federated Societies will not meet—get your abstracts ready! Edwards Bros. of Ann Arbor announce that Vols. 1, 2, and 3 of *Chemical Abstracts* (the hard ones to get to complete your set), will be lithographed and available. Also—the full 59 volumes of *Beilstein's Handbuch der Organischen Chemie* for $400.

2. *Books:* Adam Hilger (98 St. Pancras Way, London, N.W. 1), issues L. Heilmeyer's *Spectrophotometry in Medicine,* and 2nd Ed. of R. A. Morton's *Application of Absorption Spectra to Study of Vitamins, Hormones and CoEnzymes.* Cambridge Instrument Co. (England), issues descriptive pamphlet on the polarograph. G. S. Wilson gives the case for pasteurization of milk (C. Arnold, London, 1942). C. C. Thomas publishes J. Nash's *Surgical Physiology* (Springfield, Ill., 1942). American Council on Public Affairs (2153 Florida Ave., Washington), offers S. Wilson's important *Food and Drug Regulation.* Richly significant is J. Needham's *Biochemistry and Morphogenesis* (MacMillan, N. Y., 1942, $12.50). S. P. Lucia's brochure, *The Therapeutic Uses of Wine* (Wine Advisory Board, San Francisco), is good enough to be expanded to a real book. S. Dali's *Autobiography* is as rare an autopsychiatry as W. E. Leonard's *Locomotive God.* Williams & Wilkins (Balt., 1942), offer A. Mueller-Icham's *Internal Medicine in Old Age.* Interscience (N. Y., 1942), issues Vol. 2 of *Advances in Enzymology.* Columbia Press (N. Y., 1942), publishes J. T. Culbertson's *Medical Parasitology.*

3. *Blood:* F. C. Poles and M. Boycott (like J. R. Upton, San Francisco Blood Bank), report on syncope in blood donors (*Lancet,* 2:531, Nov. 7, 1942). K. E. Boorman & Co., like Tom Kelly of San Francisco, discuss clinical significance of RH factor (*Brit. Med. J.,* 2:538, 569, Nov. 7 and 14, 1942).

4. *Biochemorphology:* E. Way urges reading of P. H. Bell and R. O. Roblin's swell note (*J. Am. Chem. Soc.,* 64:2905, 1942), showing bacteriostatic power propor-

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School, Galveston, Texas.



First woman doctor in the 12th Naval District to join the Navy. Dr. Thelma G. Harmon is congratulated by Captain P. K. Gilman, U. S. Navy Medical Corps, while Lieut. Tova Petersen of the WAVES looks on. Commissioned a Lieutenant, junior grade, in the Medical Corps (Women's Reserve), Dr. Harmon has been ordered to the National Naval Medical Center at Bethseda, Md. A graduate of the University of California Medical School with the class of 1931, Dr. Harmon was in practice in San Francisco before joining the Navy.

tional to negativity of SO_2 groups of N^1 substituted sulfonamides. Also W. Alberts remarks on chemophysics of antiseptics (*Lancet*, 2:633, Nov. 28, 1942). H. Burton & Co. discuss bacterial development of colors in contact with sulfonamides as evidence of oxidation factors involved in bacteriostasis. C. B. Allsopp (*Nature*. 150:548, Nov. 7, 1942), reports a water soluble carcinogen derived fr 3:4 benzpyrene. H. J. Robinson and O. E. Graessle (*J. Pharmacol. Exp. Therap.*, 76:316, 1942), give full dope on gramacidin, tyrothricin, and tyrocidin.

5. *Industrial Toxicity:* W. C. Hueper's *Occupational Tumors and Allied Diseases* (C. C. Thomas, Springfield, Ill., 1942), is tops. R. A. Mortensen (*J. Ind. Hyg. Tox.*, 24:285, 1942), shows lead tetraethyl is lung absorbed prop. to conc. about 20 per cent of what reaches alveoli; toxic around 10 mg/kg and rapidly destroyed in tissues. C. D. McCord & Co. (*Ibid.*, p. 265), note that while indium in industry offers no risk, its cmpds. are toxic on parenteral injection—1 to 10 mg/kg, with tissue hemorrhage.

6. *Notes:* S. R. Elek and S. D. Selanz (*Am. Heart J.*, 24:821, 1942), recommend 40 mg papaverine HCl IV as safe repeatable test for circulation time—sudden deep inspiration 16 to 27 sec. in normals, longer in congestive heart trouble, shorter in hyperthyroidism. H. Lehmann & Co. (*Nature*, 150:603, Nov. 21, 1942), show amino acids increase sol. of calcium salts, and kidneys oxidases decrease it. R. E. Johnson & Co. (*J. Nut.*, 24:585, 1942), show need of B complex for men doing hard work.

Doctors at War.—Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the medical department of the United States Army and the United States Navy are on the air each Saturday at 2 P.M., Pacific War Time.

Titles, subjects and guest speakers where scheduled for the next five programs are as follows:

January 30. Wake Up America: social hygiene and the war.

Guest speaker, Surgeon General Thomas Parran, United States Public Health Service.

February 6. Rumor Monger: morale in wartime.

February 13. The Heart of a Soldier: strong hearts in the Army.

February 20. "Come and Get It"—the story of how our fighting men are fed.

February 27. "Community Fortress"—health on the home front.

Urge Speedy Naturalization of Alien Physicians.—Because of the acute shortage of civilian physicians throughout the United States, the Immigration and Naturalization Service has been directed to expedite the naturalization of alien physicians, according to a release from the Department of Justice, January 16th. Immigration Commissioner Earl G. Harrison has issued instructions to expedite the filing of petitions for naturalization and to hold hearings in advance of their regular order on the calendar in the cases of practicing alien physicians or aliens who would be qualified to practice if they were citizens. In issuing the instructions, Commissioner Harrison pointed out that many States, either by statute or by the administrative ruling of licensing boards, require applicants to establish American citizenship before they are admitted to the State licensing

examinations for the medical profession. Other States, he said, issue temporary licenses which are subject to cancellation unless citizenship is obtained within a specified period of time. The order expediting naturalization of physicians supplements instructions issued the service in January, 1942, to expedite applications for citizenship submitted by aliens in the armed forces or engaged in national defense work. In the case of physicians they are not required under the new instructions to obtain a letter from a national defense agency testifying to the nature of their employment in order to secure national defense prefcrence in naturalization. Attorney General Francis Biddle cmphasized that the new procedure in no way affects the statutory requirements for naturalization but simply expedites the handling of applications.—*J.A.M.A.*, January 30.

U. S. Medical Academy Bill Is Planned.—Washington, Feb. 2.—(UP.)—Senator Elmer Thomas (D., Okla.) said today he plans to introduce a bill calling for establishment of a U. S. Medical Academy, similar to the military and naval training schools for officers at West Point and Annapolis.

Thomas said the school is necessary because "the United States is never going to have a peacetime army of postage stamp size again and any good army must have good doctors and a sufficient supply of them."—San Francisco *Chronicle*, February 2.

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in California and Western Medicine (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50. More recent excerpts follow:

* * *

The Soul of Medicine

It has become axiomatic for those who criticize medical men opposed to a fundamental change in the American medical system, to assume that the doctors have a particular ax to grind. As a matter of fact, the doctors have only one concern: the preservation of present high medical standards. As far as financial reward goes, the average doctor could make more money under practically any other system than the present one, which far too often pays him off in nothing more tangible than the satisfaction gained from a job well done; of seeing a sick person made healthy by his skill and experience.

The doctors who today are carrying forward the best traditions of centuries of medical progress simply do not feel bound to kneel before the fancies of social reformers whose only idea of progress is the steady growth of bureaucracy.

For example, they are opposed to compulsory health insurance which is merely a polite word for socialism. Experience in Europe shows that people "protected" by such insurance do not get the medical care now provided by the American system under which the most skilled specialists and surgeons are available to all, regardless of income or economic status.

The following comment of Doctor Edward H. Cary, Chairman of the National Physicians' Committee, on compulsory insurance, expresses the viewpoint of the average doctor—a viewpoint typical of the American medical system in its approach to the whole health problem: "Compulsory insurance introduces the principle of differing qualities of medical care. It would make the doctors mercenary money grabbers and destroy their incentive to greatest efficiency. It would destroy the soul of medicine. It would undoubtedly lower the quality of medical care—and those who would suffer most would be not the doctors but the general public—those who are afflicted with disease."—Chico *Record*, January 5.

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No Time For Hysteria

So far in this war, the doctors have quietly endeavored to comply with military as well as civilian needs. Out of a total of 155,000 medical men in the nation, over forty thousand are giving their skills to the military services. And the heroic job they are doing in faraway corners of the world is well attested to by the recent comment of Admiral Ross T. McIntire, surgeon general of the Navy: "On Guadalcanal scores of doctors and hundreds of the medical corps operate American field hospitals under continuous fire. . . . We have suffered heavy casualties among our medical personnel in these operations." The Marines are no exception. The doctors are everywhere that battles are being fought.

As far as civilian health is concerned, one of the toughest problems is the nurse and the general labor shortage. But the doctors remaining at home are taking steps to alleviate this shortage, even as they are working out a definite program of civilian medical care. All that they need is coöperation on the part of the public. Securing this coöperation is not made easier by the activities of hysterical extremists who would arbitrarily ration doctors like bicycles, with the ultimate aim of socializing medicine.—Sacramento *Shopping News*, December 18.

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Doctors Limited

"The public believes, and I am afraid we have led them to believe, that we have considerable power in the control of influenza and poliomyelitis, when as a matter of fact the procedures that we now employ in these two diseases are of no demonstrated value.

"In German measles and chickenpox far too much ineffective energy is being wasted for fear the public will interpret our lack of action as willful neglect rather than lack of scientific knowledge. In the case of whooping cough more facts are needed before we can serve a very helpful purpose."

That very frank statement about American medicine was made by Dr. John L. Rice, commissioner of health, New York City, and quoted in a recent issue of the weekly bulletin of the California Department of Public Health.

Dr. Rice's admission that doctors are neither omnipotent nor infallible may come as a rude shock to some persons who far too often are prone to blame the physician when a friend or relative fails to respond to treatment, but in this flat statement of facts the New Yorker is not attempting to alibi for his profession but merely pointing out that he and his colleagues have certain limitations just as do the persons of any other profession.

Science has made great steps in combating various diseases, but there still is much to be learned, as Dr. Rice points out, and the public should bear with the men of medicine who are doing their best with the tools and knowledge they have at hand. The public should understand that failure to prevent or cure certain maladies does not necessarily mean willful neglect but usually means that the methods of combating the diseases have

not yet been discovered.—Sacramento *Union,* December 25.

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Good Health Is a Duty

Do you remember the virulent flu epidemic of 1918? When twenty million Americans were stricken?

Of these, six hundred thousand died—more than ten times the American death losses in action in the entire first World War, more than two and a half times the total of American war casualties, killed and wounded!

So far no epidemic has struck America in this war. Perhaps none will—and this is devoutly to be hoped. But diseases from malnutrition and exposure and cold are rising throughout Europe, according to news dispatches; and one of war's necessities is that ships that might carry contagion cross and recross the oceans between America and all parts of the world.

Thousands of doctors are joining the colors to care for the fighting men; and medical authorities are predicting that rationing of doctors for the civilian population is in the offing.

Such facts present to every citizen his duty to maintain his health and strength by observing common sense rules of living. A sick citizen is a loss of manpower for the war effort. A sick citizen may be a danger as a focal point for the spread of sickness to others. A man cannot help getting wet feet—but he takes needless risk by neglecting to change to dry socks and shoes as soon as he gets home. A man with a feverish cold and cough has no right, in these times, to go to shows or other crowded places where he may infect others.

Every individual and family may help greatly in holding the scourge of sickness to that irreducible minimum by eating plenty of nourishing food and taking adequate rest, by avoiding undue exposure and fatigue, by spending as many hours as possible in the open air and sunshine, and by giving attention to minor, incipient ailments as soon as they appear.

Good health has always been a priceless personal reward of common sense living. Today, good health is a wartime duty.—Hanford *Journal,* December 19.

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Do Your Part to Help the Doctor

The individual citizen can help relieve the wartime medical problem. Here are suggestions:

Choose your physician carefully and stick to him. Make appointments for visits as early as possible. Whenever advisable visit the physician's office instead of expecting him to call at your home. Write down all important facts you want to tell him. Tell him all symptoms which have any bearing on your physical welfare. Have confidence in him. Write down his orders and make sure you understand them.

Public coöperation can go far toward eliminating the "doctor shortage."—No. Sacramento *Journal,* January 15.

Smallpox in Los Angeles County.—The recent report by the Los Angeles County Health Department of a probable case of smallpox in the city of Torrance emphasizes again to the citizens of Los Angeles that this disease does exist. Although no cases have been reported for approximately four years in the city of Los Angeles, vigilant efforts must be made to prevent its recurrence.

It is important to note that for the week ending January 2, 1943, there were 5 cases reported from Indiana, 34 cases from Pennsylvania, and 7 cases from Texas. The possibility of the introduction of smallpox to the city of Los Angeles, therefore, is far from remote. It is constructive to note the effects in the city of Los Angeles of an intensive program of vaccination against smallpox in the city schools, which was begun in 1932. From 1924 through 1933, inclusive, there was an average of 682 smallpox cases per year; from 1934 to 1939, an average of 64 cases per year; and since 1939 there have been no cases reported.

It is only by the reduction of susceptibles by a continued campaign of vaccination that this dreaded disease can be eliminated.

California Historical Society.—At its meeting of January 28th, held in San Francisco, the California Historical Society elected George D. Lyman, M. D., San Francisco, President for the ensuing year. Morton R. Gibbons, M. D., San Francisco, was elected a member of the Board of Directors.

The California Historical Society publishes an illustrated quarterly containing original and authoritative articles embodying much research; publishes pamphlets and books on Western history; maintains a museum and gallery of prints and other early illustrative matter; possesses an extensive library, and holds monthly luncheon meetings at which speakers discuss interesting subjects pertaining to Western history.

Campaign to Save Hearing.—The Bulletin of the Southern California Breakfast Club — a Coördinating Council for the Hard of Hearing Societies of Southern California—and functioning as Chapter 124 of American Society for the Hard of Hearing, in its January issue, contained the following paragraphs:

"The eighteen chapters constituting the Southern California Breakfast Club and all the other Societies for the Hard of Hearing in California urge attention to this age-old problem of hearing impairment:

"Modern science and treatment have got Poor Ears licked for at least one-half of the victims. That is what the otologists and scientists tell us. But the parents don't know that yet. Modern, up-to-date testing of hearing is yet in its swaddling clothes. It is new, but is not untried. Things move so swiftly these days. It is hard to keep up.

"Please keep the two words 'Save Hearing' in mind. California should have a well-planned health program for conservation of hearing. It does not have one. . . .

"The DEAF are those in whom the sense of hearing is nonfunctional for the ordinary purposes of life. There are very few DEAF persons in our State. A well-equipped and administered School for the Deaf is provided for them at Berkeley. There are about 350 deaf children in residence there. Others are being given full education in special schools in our largest cities.

"The HARD-OF-HEARING are those in whom the sense of hearing, although impaired, is functional with or without the use of a hearing-aid. They have defective hearing but are not deaf. They should never be called DEAF. There are between 10 and 15 thousand children in California who have seriously impaired hearing. Many times that number have slight hearing loss which may develop later, unless corrected in time, into a handicapping loss."

Research on Alcohol: Award of $1.000.—The Research Council on Problems of Alcohol announces a $1.000 award, for an outstanding research on alcoholism during 1943:

1. The research for which the award will be granted must contribute new knowledge, in some branch of medicine, biology, or sociology, important to the understanding or prevention or treatment of alcoholism.

2. Any scientist in the United States, Canada or Latin America is eligible for the award.

3. The project may have been inaugurated at any time in the past or during the year 1943, provided (a) that a substantial part of the work be carried on during the year 1943, (b) that it be developed to a point at which significant conclusions are possible before the end of the year, and (c) that a report on the work has not been previously announced and described before a scientific body or previously published.

4. It is desirable, but not necessary, that those planning to work for the award send to the Council before March 1, 1943, a statement of such intention. If the Council receives such information, it can be helpful in the prevention of undesirable duplication of effort. If a research project is conceived and inaugurated later in the year, 1943, a statement of intention may be sent to the Council at a later date.

5. A report on the work and resulting conclusions must be submitted to the Research Council on Problems of Alcohol on or before February 15, 1944. The Council will provide an outline for use in the preparation of reports.

6. The award will be in cash, and will be given to an individual scientist whose work is judged sufficiently outstanding and significant to merit the award.

7. The Committee of Award will consist of five persons—an officer of the American Association for the Advancement of Science, and four representatives of the Scientific Committee of the Research Council on Problems of Alcohol.

8. If the Committee is not convinced of the outstanding merit of the research done during 1943 as described in reports submitted, it may, at its discretion, postpone the award until another year, or until such time as work of such merit has been performed.

The Council will send on request, to any scientist, an outline of basic policies governing its research program, lists of Council studies (completed, under way and contemplated), and information regarding the studies of other agencies.

Scientists planning to do research in connection with the award may send a statement of intention to the Director, the Research Council on Problems of Alcohol, Pondfield Road West, Bronxville, New York.

Social Hygiene Takes Battle Stations.—Social Hygiene Day, sponsored annually by the American Social Hygiene Association, 1790 Broadway, New York, was observed on February 3, 1943. Communities throughout the United States and its territories held local meetings where the American public gathered to discuss the problem of venereal disease control during the war. Stressing the urgent wartime need for a vigorous offensive against the venereal diseases, the Association's theme for the 1943 campaign was "Social Hygiene Takes Battle Stations."

Infantile Paralysis: Grants to California Schools.—In a recent bulletin, the National Foundation for Infantile Paralysis calls attention to the general expansion and intensification of the nation-wide fight against infantile paralysis, with progress made in scientific attacks on the crippling disease. . . .

The included financial statement reveals 77 grants and appropriations totaling $1,142,009.35 for the fiscal year ended September 30, 1942. The money was disbursed to medical schools, hospitals, research laboratories, health institutes and foundations, from funds raised by the "March of Dimes" and Celebrations of President Roosevelt's Birthday. . . .

For virus research the National Foundation made 23 grants to 21 institutions for a total of $543,749.46. Of the grants seven were to men or institutions whose work had not previously been supported by the Foundation.

Among the grants were: George Williams Hooper Foundation of the University of California, San Francisco, $21,526; Stanford University School of Medicine, San Francisco, $10,035; University of Southern California School of Medicine, Los Angeles, $10,000. . . .

For educational purposes there were three appropriations and 12 grants to 10 institutions in 7 States, the total amount being $227,540.80. Principal grants were: Stanford University School of Health (Women), Palo Alto, California, $9,520. . . .

World War I: Syphilis Cases.—During the first World War there were 157,146 more new cases of syphilis and gonorrhea among United States soldiers, sailors, and marines than there were wounds in battle itself. Total absences from duty due to this cause kept the equivalent of 20,600 men out of the fighting for a whole year. The loss in terms of today's hardheld fronts: twenty thousand men would man five huge aircraft carriers and nine destroyers.

Rationing of Canned Milk Unnecessary: Temporary Shortages Due to Hoarding, Say Manufacturers.—Housewives who have had to shop from store to store to get sufficient evaporated milk for the baby's formula can take comfort from the statement of Dr. Frank E. Rice, Executive Secretary of the Evaporated Milk Association, that shortages of canned milk are being relieved rapidly. Manufacturers of evaporated milk from all parts of the country, meeting in Chicago recently, report that production is on the increase, normal supplies are being released to the trade, and grocers' shelves will be additionally replenished from the huge stocks of evaporated milk held by the government. . . .

"The recent announcement that O.P.A. had been granted authority by Secretary Wickard to ration evaporated milk is most unfortunate, coming at this time," said Doctor Rice, "since it will only aggravate hoarding and prolong the temporary shortage. The capacity of the industry to produce evaporated milk is ample to take care of all requirements which can be foreseen at this time for 1943."

Kenny Method in Infantile Paralysis.—In an open letter to all Chapters, the National Foundation for Infantile Paralysis makes the following statements:

It is vitally important that all Chapters of the National Foundation, and all hospitals admitting infantile paralysis patients, know what the Kenny method is and who can apply it.

The Kenny method is not a "cure" for infantile paralysis. It *is* the most satisfactory method yet developed for *treating* early cases; it is not designed for treatment of long-standing cases. The earlier the treatment is provided the better it will be for the patient. The treatment should start the day the diagnosis is made. Every day's delay may add weeks to the period of hospitalization. Cases can be treated after several weeks', or even months' delay, but the results may not be so good. Certainly the treatment will be prolonged, causing unnecessary expense and misery.

The Kenny method of treatment is based not upon the older concept of the symptoms but rather upon a new idea advanced by Miss Kenny. This idea has been put to many tests and has been found so far to be sound and based on well recognized principles of pathology and physiology. The method is neither easy to understand nor easy to learn. Long periods of study and supervised

practice are necessary to produce the best results with patients. In the hands of the untrained, failure is bound to result.

In addition to the doctor having knowledge of this method, it is necessary to have two other kinds of professional help. First, there is the nurse, and secondly, there is the physical therapy technician. Each has her part to play and each job is important. The training for the two jobs is quite different. . . .

Training for the physician can be provided in one week. This is needed so that he can properly supervise and direct the work of the nurses and physical therapy technicians.

The National Foundation frequently has been asked how many trained persons should be available in any community. This cannot be easily answered. Certainly every children's hospital and every contagious disease hospital should have at least one doctor and one physical therapist as well as one or more nurses. Training centers have been set up at:

Stanford University, California.

University of Southern California, at Los Angeles. . . .

These all have been furnished funds by the National Foundation, so the tuition costs are very low. Information as to costs, dates of courses and admission policies can be obtained directly from these schools.

Red Cross Sets $125,000.000 As War Fund Needs for 1943.—With a goal of $125 000 000 for its 1943 War Fund, the American Red Cross will embark upon the biggest campaign in its history on March 1.

Millions of volunteers will be recruited to assist in the nation-wide appeal, which will be conducted under the direction of Walter S. Gifford, president of the American Telephone and Telegraph Company, who is national chairman of the 1943 Red Cross War Fund. . . .

"Of the total goal, $45 000 000 is the sum required by Red Cross chapters to finance their indispensable needs and their ever-increasing local work on behalf of families of men in the service. The remainder, or $80 000 000, will go to the national organization which, however, requires one hundred million dollars to finance its national and international program. The difference will be met by a balance of $20 000 000 from the first War Fund of 1942 which will be applied to the 1943 budget."

Chairman Davis emphasized that more than 65 per cent of the amount required by the national organization has been budgeted for Red Cross services to the armed forces.

With the approval of President Roosevelt, March will be observed as Red Cross Month in every city, town, and hamlet covered by the 3750 Red Cross chapters and their 6,154 branches. All walks of community life will be represented in the campaign.

The customary Red Cross membership Roll Call was dispensed with last November when the Red Cross decided upon one campaign in March which, barring emergencies, will finance its work until February 28, 1944.

Effective Control of Communicable Disease Depends Upon Complete and Prompt Reporting.—Health Officer Uhl of Los Angeles City stated in a recent bulletin that communicable diseases were not being completely reported in the Los Angeles area. The City Health Department had recently made a check on the efficiency of reporting certain diseases and found that in too many instances physicians either neglected to report at all or their reports were incomplete.

"Now more than ever before is complete reporting essential. Epidemic diseases cannot be controlled unless there is prompt isolation of early cases and segregation and observation of susceptible contacts. The Health Department has suffered losses in trained personnel and many additional duties have been imposed, due to the war, but the protection of the public against communicable disease is still first among our responsibilities and we intend to discharge it to the limit of our ability.

"The Health and Safety Code requires that physicians and others promptly report to the Health Officer all communicable diseases, giving name, address, and nature of disease, if known. Any person failing to so report is guilty of a misdemeanor and may be charged with committing a separate offense for each day the violation continues.

"The Health Officer has no desire to prosecute fellow physicians. He does have, however, certain responsibilities and duties to perform, negligence of which makes him subject to legal penalties. It is, therefore, strongly advised that physicians promptly report every case of communicable disease coming to their attention."

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Charity Group Fights $25,000 Salary Limit*

New York, Feb. 2.—A significant warning that the recently imposed $25,000 income ceiling threatens to cripple many charitable, educational and religious institutions was issued today by the New York Infirmary for Women and Children.

The board of directors, headed by Mrs. Frank A. Vanderlip, has voted to appoint a special committee to take up with other hospitals and charities the possibility of a joint appeal to Congress against the $25,000 ceiling.

Based on Charity

A public statement by the Board says:

"Like countless other charitable, educational and religious institutions in America, this hospital probably would never have been created or maintained in a country which had limited opportunity in individual money making efforts.

"The Board unanimously agreed that institutions like the Infirmary may be permanently crippled if contributions were withdrawn by individuals affected by the new ruling.

"Mrs. Vanderlip pointed out that the New York Infirmary for Women and Children, founded ninety years ago by the first woman to receive a medical degree, Dr. Elizabeth Blackwell, with a small donation of $600, has been able to maintain itself through these years by receiving at least two-thirds of its funds through generous donations from individuals.

"The report of the treasurer indicated that the year closed with no deficit. By extreme economies and self-sacrifices the budget of $334,000 was met.

"Patients of the hospital paid in $187,000, with the remaining $147,000 earned through individual donations, United Hospital and Greater New York funds, plus various benefits conducted by the volunteer workers of the hospital board.

Standards Maintained

"The hospital last year cared for 3,563 bed patients and 6,536 dispensary patients. There were 65 active nurses' aides and about 35 other volunteer helpers who contributed 27,572 voluntary hours in 1942, in addition to the work performed by the paid staff of the hospital.

"It was also agreed that its medical efforts and service as a hospital to the community had been maintained at the highest possible standard entirely through the combined efforts of individuals contributing services and funds."

Learning From Disaster

From Boston's tragic night club fire, physicians, and emergency relief organizations have learned a number of lessons which are being transmitted to similar groups in other cities.

In the *Journal* of the American Medical Association, Dr. N. W. Faxon and Dr. E. D. Churchill credit the Wartime Civilian Defense program with having made the

* For editorial reference, see page 58.

community "catastrophe-minded" and with aiding the hospital organization in treating the scores of wounded.

Despite the apparent confusion, "it was obvious to those responsible for organization that every one was acting rapidly, efficiently and intelligently." The doctors found adequate supplies for treating the patients. They suggested that catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the injury, the presence of noxious fumes and so on, not solely to fix the responsibilities from a legal standpoint, but to aid in the treatment of casualties.

Other recommendations urged concentration of casualties into groups for treatment and organization of hospital staffs into teams for undressing patients, caring for clothes and valuables and treating patients.—Oakland *Tribune*, December 26.

Disaster Lessons Learned In Fire

Boston Doctors Urge Information Service

Chicago (UP.)—Two Boston physicians, reviewing lessons learned in the recent Boston night club fire disaster, recommended today that disaster relief organizations be prepared to supply essential information to medical authorities.

Dr. N. W. Faxon and Dr. E. D. Churchill wrote in the *Journal* of the American Medical Association that the wartime civilian defense program had made Boston's hospital organization "catastrophe-minded" and had aided it in treating the scores of injured.

Rapid and Efficient

Despite the apparent confusion, they said, "it was obvious to those responsible for organization that every one was acting rapidly, efficiently and intelligently." The doctors found adequate supplies for treating all patients.

"One important defect in the casualty organization appeared in an unexpected quarter," Faxon and Churchill said. "It was impossible for those responsible for the care of the survivors to secure adequate information regarding the character of the trauma.

"The predominant clinical pattern of flesh burns and severe damage to the respiratory tract was apparent by 1 a.m. An inquiry was directed to authorities, but no information regarding the disaster could be obtained. The question of poisonous fumes immediately was raised, but definite evidence on this point was lacking.

Urge Quick Autopsies

"Catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the trauma, the presence of noxious fumes and so on, not solely to fix the responsibilities from a legal standpoint, but to aid in the treatment of casualties. Examination of the dead by competent pathologists well might begin immediately and their findings communicated to clinicians."

The physicians said that the value of a well-organized telephone system also was evident and added that their own system "functioned but can be much improved."

Other recommendations urged concentration of casualties into groups for treatment and organization of hospital staffs into teams for undressing patients, caring for clothes and valuables and treating patients. — Santa Monica *Outlook*, December 24.

Identification Bracelets For Women Urged After Fire

Chicago, Dec. 28. — (AP.) — Recommendations that women wear identification bracelets and that catastrophe organizations include experts on gasses were made today as a result of the Cocoanut Grove holocaust in Boston.

The suggestions were included in a preliminary report in the *Journal* of the American Medical Association by Dr. N. W. Faxon and Dr. E. D. Churchill, director and chief, respectively, of the West Surgical Service of the Massachusetts General Hospital there.

In reporting medical lessons learned from the handling of patients from the night club fire November 28th, which claimed 488 lives, they commented:

"None of the women had anything on their persons that permitted immediate identification. Their outer coats had been deposited in check rooms and they had become separated from their purses and bags.

Bracelet or Anklet

"This suggests the recommendation of a standard method of identification for women by bracelet, anklet or some similar method."

The physicians said that "one important defect in the casualty organization appeared in an unexpected quarter. It was impossible for those responsible for the care of the survivors to secure adequate information regarding the character of the trauma (injury).

"The predominant clinical pattern of flesh burns and severe damage to the respiratory tract was apparent by 1 a.m. An inquiry was directed to authorities, but no information regarding the disaster could be obtained. The question of poisonous fumes was immediately raised, but definite evidence of this point is still lacking.

"Catastrophe organization might well include experts assigned to the scene of disaster to determine the nature of the trauma, the presence of noxious fumes and so on, not solely to fix the responsibility from a legal standpoint, but to aid in the treatment of casualties."

A full report on lung damage, from gases, "must await definite evidence regarding the nature of the products of combustion that were released by the fire," the physicians said.

Other Recommendations

Other recommendations for such disasters included: Immediate examination of the dead by competent pathologists, to guide physicians treating others injured; separation of the living and dead at the very entrance of the hospital; organization and division of doctors and nurses into teams; keeping casualties in one group for concentrated medical treatment; giving an official count and list of identified dead to police and press "as quickly as possible."

"The need for a hospital organization for handling of emergency disasters and the collection of an ample quantity of emergency supplies is obvious," they said.

"Thanks to the efforts of the civilian defense, we had been made 'catastrophe-minded.' Owing to practice mobilization and widespread information regarding disaster management, every one performed his duties without orders. . . . Furthermore, the quantity of supplies on hand proved adequate, and no shortage of anything was experienced.

"'An emergency anticipated and prepared for ceases to be an emergency.'"—Oakland *Tribune*, December 28.

Painless Childbirth Possible, Doctors Say

Chicago, Jan. 21.—Two physicians today reported successful use of a new method of providing painless, safe childbirth, one of the long sought goals of the medical profession.

The *Journal* of the American Medical Association in which the report appeared, commented editorially that the method "constitutes a real advance in securing relief of pain for mothers during childbirth."

The physicians, Dr. Robert A. Hingson and Dr. Waldo B. Edwards of the U. S. Public Health Service Marine Hospital on Staten Island, N. Y., reported they had used the method in 589 cases, involving 586 live births, "with no maternal complications or deaths."

Their method involves continuous injection of a solution of metycaine, a cocaine substitute, into the lower tip of the spine. It is called "continuous caudal analgesia."

Among the advantages claimed for their method:

1. The patient is not uncomfortable, often enjoys natural sleep and is able to conserve energy.

2. The danger of precipitant birth is minimized. Breech deliveries are greatly facilitated. The premature baby enjoys a better than average chance for survival. There is a noticeable decrease in blood loss.

3. The method can be started in any stage of labor and be continued as long as necessary. Post-delivery complications are reduced. Uterine contractions continue without impediment. The patient remains conscious during delivery.—San Francisco *News*, January 21.

New Painless Childbirth Method Tested Out on Discoverers' Wives

New York, Jan. 21.—(INS.)—The new anodyne which makes childbirth so painless that a mother can read a book while her baby arrives was tested on the wives of the two young physicians who developed the technique, it was disclosed today.

Announcement of the new method called continuous caudal analgesia was made yesterday in Chicago through the American Medical Association *Journal*.

Its devisors, Dr. Robert A. Hingson and Dr. Waldo B. Edwards, employed the method in 589 cases with results "almost 100 per cent" effective.

In the case of Doctor Hingson's wife, it was her first baby and Dr. Donald W. Patrick, one of the attending physicians, said Mrs. Hingson "took the whole thing easily and as a matter of course." She could not appreciate the pain she was being saved, it was said.

Doctor Edward's wife was most enthusiastic as the method was employed as she gave birth to her third

child, and she could realize the suffering it avoided.—San Francisco *Examiner,* January 22.

Heart Disease and Cancer Most Liable to Prove Fatal

Tuberculosis, Pneumonia and Appendicitis Held Most Dangerous for Average Person Decade Ago

Heart disease or cancer, in that order, are more liable to carry you off, when your time comes, than a decade ago, when tuberculosis, pneumonia and appendicitis were more prevalent fatal ailments.

This trend is according to the Bureau of the Census, which yesterday released figures on comparative death causes in California in 1941 and 1931.

Also noteworthy was a drop in deaths from whooping cough, diphtheria, scarlet fever and spinal meningitis—chiefly children's diseases. In 1931 these caused the death of 9.1 persons out of 100,000, and 10 years later only 2.8.

While tuberculosis a decade ago caused 91.1 deaths per 100,000 population, the proportion has dropped to 54.3 per 100,000. Cancer in 1931 took a toll of 127 per 100,000 but in 1941 claimed 148.8, while the figures on heart disease rose from 276.7 to 367.4 per 100,000.

Pneumonia was fatal to 83.9 per 100,000 in 1931, but only 50.4 in 1941. Appendicitis claimed 14.3 per 100,000 a decade ago; in 1941, 7.6. Pregnancy and childbirth diseases dropped from 8.7 in 1931 to 4.1.

Homicides, suicides and nontraffic deaths were lower, but traffic deaths were higher in 1941, the figures showed. —Los Angeles *Times,* January 21.

Warren Orders Probe of Chiropractic Board

Sacramento, Jan. 22.—(INS.)—Admitting "something is doing" regarding the State Board of Chiropractic Examiners, Governor Warren revealed today the attorney general and the district attorney of Los Angeles County had been asked to investigate the board.

"It has developed," Warren charged, "that the board has been giving examinations not as a board but as individuals of the board.

"This matter is being investigated by the attorney general, who in turn some days ago placed the matter in the hands of the district attorney of Los Angeles County."

Warren said further details were in the hands of Attorney General Robert W. Kenny and John Dockweiler, district attorney of Los Angeles County.—San Francisco *Call-Bulletin,* January 22.

Chiropractic Board Accused of Taking Fees

Warren Charges Some Members Charged $100 for Special Examination for License

Some members of the Olson appointed State Board of Chiropractic Examiners have been giving examinations as individuals, charging $100 and pocketing the money, Governor Warren charged at Sacramento yesterday.

He disclosed that Attorney General Robert Kenny is investigating the board with the assistance of the district attorney at Los Angeles and that the president of the board has resigned.

Replying at his press conference to a question as to whether the board was under scrutiny, the Governor said:

"Since you ask me, the answer is yes.

"I am sorry that I cannot give you accurate details. However, it has developed that the chiropractic board has been giving examinations not as a board but as individuals on the board."

Charging $100 Apiece

"It also has developed that at least a majority of the board has been charging applicants $100 apiece, the $100 going not to the State but to members of the board.

"It also has developed that the questions to be asked were put in a position where the applicant could see them beforehand.

"It also is my information—I cannot say positively—that everyone who took the examination this way and paid the $100 passed.

"I have not requested any resignations. I am awaiting the action of the attorney general and the district attorney. I am informed that one member of the board admits giving twelve such examinations."

Kenny, confirmimng the investigation at his office here, said the inquiry is centered in Southern California. . . . —San Francisco *Examiner,* January 23.

New Mental Clinic Set Up

Los Angeles Making Effort to Cope With Nervous Diseases

Los Angeles is making a start in the prevention of nervous and mental diseases, currently on the upswing because of war tensions, it was learned yesterday when Olin Wellborn III, president of the Council of Social Agencies of Los Angeles, announced the establishment of this community's first psychiatric clinic for adults.

The clinic, at Cedars of Lebanon Hospital, is financed on a one year demonstration basis by a special grant of Community Chest funds authorized by the Community Welfare Federation.

Volunteer Board

Known as the Los Angeles Psychiatric Service, the clinic is operated by a volunteer board of directors composed of business, professional and civic leaders interested in social welfare. Dr. Glenn Myers is chairman of the board.

Although war has increased the number of mental and nervous breakdown cases, Wellborn made it plain that the present psychiatric program is not being undertaken strictly as an emergency measure.

"The need existed long before the war," he said. "What was a vital need in peacetime has merely become a wartime necessity."

List of Directors

Members of the board of directors of the new clinic are E. Vincent Askey, M. D., City Board of Education; Milton Baruch, building contractor; LeRoy Bruce, director, Los Angeles County General Hospital; Mrs. Ernest A. Bryant, Jr., Los Angeles Visiting Nurse Association; Philip M. Connelly, Los Angeles Industrial Union Council; Mrs. Blythe Francis, executive secretary, Family Welfare Association of Los Angeles; Fred S. Hilpert, vice-president, Farmers & Merchants National Bank; Mrs. Ruby Inlow, graduate school of social work, S. C.; Arlien Johnson, Ph.D., graduate school of social work, University of Southern California; Walter Mezger, superintendent, Cedars of Lebanon Hospital; Msgr. Thomas J. O'Dwyer, Catholic Welfare Bureau; Ray W. Smith, manager, Downtown Business Men's Association · Mrs. Sumner Spaulding, Council of Social Agencies; Ellen Sullivan, Ph.D., psychology department, University of California at Los Angeles; Walter Treadway, regional director, United States Public Health Service, and Eugene Ziskind, M. D.—Los Angeles *Times,* January 18.

Hospital Ward Grant Sought in San Bernardino

An outright grant of $68,500 to finance the proposed construction of an isolation ward at San Bernardino county's hospital was requested today by the board of supervisors in an application to the defense public works administration.

The board some months ago submitted a request for a $50,000 grant but the estimates of experts of the U. S. Public Health Bureau, who proposed the construction of the ward to replace the existing facilities at the hospital, were increased in a revised program.

Under the U. S. Public Health Bureau's proposal, the Federal government would construct the ward which would serve both the general public and soldiers in the district in the event of an epidemic of contagious disease.—San Bernardino *Telegram,* January 4.

U. S. Syphilis Rate Estimated

Chicago, Dec. 24.—(UP.)—Of every 1,000 men in the nation between the ages of 21 and 35, an estimated 47.7 have syphilis, it was reported today in the *Journal* of the American Medical Association.

This estimate is based on serologic blood test reports of 1,895,778 white and Negro men between these ages tested under provisions of the Selective Service Act.

More city men were found to be afflicted than men from rural areas. The highest prevalence rates in the study were found in the Southeastern states. The rates rise sharply with increasing age. It was explained that this is due to a constantly accumulating backlog of uncured syphilis.—San Francisco *News,* December 24.

Stanford Doctor Describes Powerful New 'Pep Pill'

Drug Routs Sleep and Weariness

A powerful new sleep-preventing "pep" pill which can keep a man fully alert for 18 to 24 hours was described by a Stanford University pharmacology professor today.

Dr. Maurice Tainter told a meeting of the Society of Experimental Biology and Medicine in San Francisco that only one ten-thousandth of an ounce of the drug, methylbenzedrine (a derivative of the commonly known benzedrine), produces unmistakable stimulation which makes a person think more clearly and react faster hour after hour until the effect wears off, permitting normal sleep.

A dose of three to four thousandths of an ounce, he said, will prevent sleep for 24 hours, but causes nervousness. A larger amount may be fatal.

The substance is roughly 80 times as strong as the caffeine in coffee and twice as potent as adrenalin or ordinary benzedrine, Dr. Tainter explained.

Dr. Tainter said he and Dr. Armando Novelli, who worked at the faculty of medicine in Buenos Aires, Argentina, had been experimenting with methyl-benzedrine since 1938.

Germany and Denmark also have been working on the drug, and Dr. Tainter said there have been indications that methyl-benzedrine pills have been given German aviators and tank crews to enable them to perform seemingly superhuman tasks of endurance.

The drug has been used to treat victims of nervous oreakdown and persons who are dull and depressed or "can't wake up in the morning." In Europe, patients given the preparation have recuperated more quickly after operations, he said.—Palo Alto *Times*, December 24.

Dr. J. B. Harris Heads Medical Academy

Dr. Junius B. Harris has been elected president of the California Academy of Medicine to succeed Dr. Loren Chandler, dean of the Stanford Medical College. Drs. Dan Moulton of Chico, Butte County, and George Sanderson of Stockton, San Joaquin County, were named on the executive committee.

The California Academy of Medicine was formed in 1870.—Sacramento *Bee*, January 14.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Legal Relationship of Physician and Patient as Affecting Business Transactions Between Them

The legal relationship existing between physician and patient is universally characterized by the courts as being one of trust and confidence, similar in this respect to the relationship of attorney and client or trustee and beneficiary. By reason of this confidential relationship, certain implications arise with respect to all transactions between the parties and as was said in *Cole v. Wolfskill*, 49 Cal. App. 54: "Once this relationship is shown to exist all dealings between the parties will be closely scrutinized to ascertain whether the confidence of the trusting party (the patient) has been betrayed or his mind unduly influenced to his prejudice."

The courts not only subject business dealings between physician and patient to a careful examination whenever their validity or freedom from fraud is questioned, but take the further step of basing a presumption of undue influence on the legal relationship of physician and patient, and wherever it is shown that a physician was presented with some opportunity for deception, such as weakness of intellect on the part of the patient or advanced years, the court will presume that the physician practiced a deception or acted unconscientiously. The net result of this presumption is that the burden is cast upon the physician to prove that in the particular transaction the patient acted intelligently and with full knowledge of the consequences of his act. This theory of the law, reasonable or unreasonable as it may be in the particular case, comes into play whenever a patient takes some action beneficial to the physician, such as making him a devisee or legatee in his will, or deeding property to him.

An illustration of the doctrine is presented by the case of *MacCaulay v. Booth*, 53 A.C.A. 968, decided August 1, 1942. There the patient was suffering from a number of serious ailments and in the early part of 1937 moved from his city residence to a country locality where the defendant physician undertook his treatment, the relationship of physician and patient existing from May, 1937, until the death of the patient in January, 1938. During this period, the attendance of the physician was very frequent, amounting to several visits each week and the treatment was extensive. The evidence adduced at the trial was to the effect that the patient was in financial difficulty and therefore unable to make payment for the medical services rendered in the usual manner, and that, accordingly, he executed and delivered to the physician a promissory note in an amount slightly exceeding $1,000.00, representing the obligation due the physician for medical services rendered from May, 1937, to January, 1938. The promissory note was secured by a deed of trust upon the premises in which the patient resided and the entire transaction took place the day before the patient's death. The requisite papers were prepared by the patient's attorney and were signed and delivered in the presence of the physician, the attorney and the plaintiff in the instant case, who filed suit after the death of the patient to cancel the trust deed and promissory note.

The plaintiff held a deed of gift of the property executed by the patient some time prior to his death and prior to the deed of trust delivered to the physician and filed suit to set aside the physician's deed on the grounds that the patient was entirely without understanding at the time of the execution of the instruments and that the physician as such had failed to respect the confidential relationship existing between the patient and himself and had gained an unfair advantage in the transaction.

The evidence introduced in the trial court showed that the plaintiff had assisted the patient in signing the necessary papers and that the plaintiff as well as the patient's attorney had been there during the entire transaction and neither had raised any objection at the time. The evidence on the patient's competency at the time was contradictory, but the trial court rendered judgment in favor of the defendant physician, upholding the validity of the promissory note and the deed of trust which he held.

On appeal, the District Court affirmed the judgment holding that the evidence was sufficient to overcome any presumption of undue influence on the part of the physician. The Court reiterated

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

the rule that the confidential relationship between physician and patient necessitates a close examination of all dealings between such parties in order to protect a person in a weakened condition peculiarly subject to suggestions on the part of his physician in whom he must repose a certain amount of confidence and trust. It was held, however, that independent advice was not indispensable to negative the presumption of undue influence. This presumption the court pointed out is by no means conclusive and if at the trial the physician produces sufficient evidence that the patient acted voluntarily and with a full appreciation of the consequences of his act, the transaction will be sustained notwithstanding the confidential relationship.

LETTERS†

Concerning Medical Literature to Station Hospitals of Military Camps Located in California

Editor's Note.—In the January issue, report was given and comment made concerning medical journals and books sent by the C.M.A. Postgraduate Committee, to Colleagues in Military Service. (January CALIFORNIA AND WESTERN MEDICINE, page 3.) A letter from the Postgraduate Committee to Medical Officers in Command appears below. Also some replies:

CALIFORNIA MEDICAL ASSOCIATION

Scientific Assembly: Committee on Postgraduate Activities

San Francisco, January 29, 1943.

To: *The Medical Officer in Command.*

STATION HOSPITAL

————, California

FROM: *C.M.A. Postgraduate Committee.*

SUBJECT: *"California and Western Medicine," official journal of California Medical Association.*

Dear Doctor:

Because your Camp is located in California, members of your Hospital Station may be interested in scanning the pages of CALIFORNIA AND WESTERN MEDICINE, official journal of the California Medical Association.

The C.M.A. Postgraduate Committee has arranged to have your Camp placed on the *complimentary mailing list of C. and W. M.*, to permit the JOURNAL to be available in your Station library.

The roster of County Medical Societies appears in each issue, in the front advertising section, on advertising page 4. We know that the members of the local society of the county in which your own Camp is located, will be glad to have members of your own staff feel free to attend and take part in county society meetings.

We also take the liberty of calling your attention to the addresses of the medical libraries in California, on advertising page 5.

Medical news, of a military nature, appears in each issue of C. and W. M., under the caption, "California Committee on Participation of the Medical Profession in the War Effort."

With good wishes, and hoping you will feel free to inform us if, at any time, you think we can be of service.

Cordially and fraternally,

C.M.A. POSTGRADUATE COMMITTEE
By GEORGE H. KRESS, M. D.,
Secretary-Editor.

* * *

STATION HOSPITAL
OFFICE OF THE SURGEON
Fort ————, California

February 1, 1943.

Dear Dr. Kress:

Thank you very much for your letter of January 29, 1943, and for the copies of CALIFORNIA AND WESTERN MEDICINE which were received some time ago.

Several members of our staff are California doctors, and they, as well as the rest of us, will enjoy and profit by perusing your journals, I am sure.

Thanking you again for the sentiments expressed in your letter of January 29th, I am,

Yours sincerely,
(Signed) ————,
Colonel, Medical Corps,
Surgeon.

* * *

STATION HOSPITAL
OFFICE OF THE SURGEON
———— Flying School
————, Californa

February 1, 1943.

To: *C.M.A. Postgraduate Committee,*
San Francisco, California.

Gentlemen:

Your letter of January 29, 1943, in which you have stated that this camp has been placed on the complimentary mailing list of C. and W. M., has been received and I wish to thank you for the staff, as a whole, for your consideration, and am quite sure it will aid considerably in keeping contact with the medical world outside.

You may be assured that you will be called upon if, at any time, we think you can be of service. Also, the libraries will be used frequently.

Cordially and fraternally,
(Signed) ————,
Major, Medical Corps,
Surgeon.

* * *

———— A.A.F. FLYING TRAINING DETACHMENT
OFFICE OF THE SURGEON
————, Californa

December 28, 1942.

SUBJECT: *Medical Literature.*

To: *California Medical Association, 450 Sutter Street,*
San Francisco, California.

1. In receipt of copy of C. & W. M., and letter your office, dated December 24, 1942, same subject, both of which are sincerely appreciated.

2. This effort as presented on page 230, October issue of C. & W. M., in our opinion will be equally appreciated by all Medical Officers in the Armed Forces. The C. & W. M. itself contains considerable information of interest to both of us, and we shall be very highly appreciative if we can be kept on its mailing list.

3. It so happens that Dr. ——— prior to entering into the Armed Forces has been a pathologist, and myself, an E.E.N.T. Specialist, and we would both sincerely appreciate literature on these respective subjects, if it can at all be possible.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

4. Once again, may I extend our sincerest thanks for the literature also received, and for the consideration your society has shown us Service men in this effort, and I feel certain that our feelings are shared by all the other Army Medicos fortunate enough to receive the same consideration.

(Signed) ————,
Captain, Medical Corps,
Surgeon.

HEADQUARTERS ———— AIR FORCE
OFFICE OF THE SURGEON
December 31, 1942.

My dear Doctor:

The volume of Gray's Anatomy, which was sent by your library, has recently been received in this office. It will make a very welcome addition to our present rather meager medical library and I can assure you that its receipt is very greatly appreciated.

Very sincerely yours,
(Signed) ————,
Colonel, Medical Corps,
Surgeon.

STATION HOSPITAL
ARMY AIR FORCES ADVANCED FLYING SCHOOL
————, California
January 13, 1943.

California Medical Association,
450 Sutter Street,
San Francisco, California.
Gentlemen:

This Station Hospital has again received medical books sent by you. The staff wishes to again thank the California Medical Association for this donation. Your efforts on our behalf are greatly appreciated.

Very truly yours,
(Signed) ————,
Major, Medical Corps,
Executive Officer.

Concerning Proposed Amendments to Medical Practice Act

(COPY)
State of California
Department of
PROFESSIONAL AND VOCATIONAL STANDARDS
Board of Medical Examiners
Sacramento, California, January 8, 1943.
Re: Temporary licenses.

Dear Doctor Kress:

Some indication of the difficulties which will confront California in case a measure is supported authorizing the issuing of temporary licenses will be found in an article by S. D. Van Meter, former secretary of the Colorado Board, which article was printed in the American Medical Association *Journal* of February 3, 1906, and was entitled "Medical Forgeries."

The Council on Medical Education of the American Medical Association in their Bulletin No. 19, entitled "Correspondence, Edward Dowdall and James C. Jones" further bring out our point. The medical licensure literature is filled with cases where imposters endeavored to obtain a medical license on fraudulent credentials.

The undersigned had the following articles published in the *Bulletin* of the Federation of Medical Examining Boards:

1. Carnagey College of Medicine (Fraudulent).
2. Eligibility for a License.
3. The National University of Belgium.
4. A Prison-Hatched Diploma Mill.
5. Safeguarding State Board Records.
6. A Study in Diplomas.
7. Legal Checks in California on the Practice of Medicine.
8. Uniform Standards of Licensure.
9. Samuel A. Cheatham.
10. Philip Dyment.
11. Galen R. Hickok.
12. Peter Le Roux, alias "Dr. Alf. A. Hesse".
13. Hamilton McClarty.
14. George Timothy O'Sullivan.
15. Arthur Edmund Webb.

The proposed legislation must be drawn very carefully; otherwise it will prove to be a boomerang.

Very truly yours,
(Signed) C. B. PINKHAM, M. D.
Secretary-Treasurer.

Concerning Procedure in Application for Registration

(COPY)
BOARD OF MEDICAL EXAMINERS OF THE
STATE OF CALIFORNIA
January 5, 1943.
Re: Application.

Dear Doctor:

We are still awaiting the receipt of a certified copy of a letter written by the Northwestern University Medical School to the Illinois Department of Registration and Education prior to your admission to their examination, said letter stating that you had passed all of your final examinations at the time of admission to examination and had fulfilled all of the medical school requirements for the issuance of your medical diploma. This certified copy of letter is necessary inasmuch as you were admitted to examination in the State of Illinois sometime prior to your having been granted the degree "Doctor of Medicine" by Northwestern University Medical School.

You would not have been admitted to examination for a license to practice in the State of California unless you were the possessor of a medical diploma. The California law requires that the State which issued the license used as the basis of application must have maintained a standard equal to California on the same date. In your particular instance the Illinois Board did not fulfil this requirement inasmuch as they admitted you to examination on June 28, 1927, whereas your medical diploma bears the date June 18, 1928.

We return herewith enclosed pages 1 and 2 of a supplemental reciprocity application drawing your attention to your failure to complete same in accordance with the printed instructions.

Awaiting your pleasure, believe me,
Very truly yours,
C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning California Legal Procedure in re: Foreign Medical Graduates*

December 30, 1942.

Dr. ————,
Addressed.

Subject: Yours of December 21st.
Re: Application.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Dear Doctor:

This will acknowledge receipt of your letter advising you hold an M. D. degree issued in 1922 by the ———— University, and that you were licensed to practice in the State of New York in December, 1942.

Enclosed herewith please find our printed form 172-173 which will give you full information as to California's requirements exacted of graduates of foreign medical schools. You will notice on our form 173 information relative to reciprocity. If, prior to your admission to the New York medical board examination, you did not fulfill all of California's requirements exacted of foreign medical school graduates, you will not be acceptable on a reciprocity basis.

Your letter relates that you have had "three months at the Hospital of St. Anthony of Padue, in Chicago, Illinois." This institution is on the approved list. However, in addition to other requirements, it will be necessary for you to complete a one-year internship in that hospital prior to your being eligible for admission to examination in the State of California.

Awaiting your compliance with the statutory provisions as outlined on the enclosed printed form 173, believe me

Very truly yours,
(Signed) C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning a Spurious Check-Passer

January 13, 1943.

To the Editor:

This letter is sent to call attention to a check-passer who is evidently operating in California cities. His method of procedure in mulcting doctors is somewhat as follows:

He enters a doctor's office, states his wishes to have a Wassermann Test made, and before starting the work, begs to be excused because his automobile is parked and he wishes to change its location. In this way, he gives the impression of having means (a build-up).

In paying for his Wassermann, he states he also wishes to pay at the same time for his wife and daughter who will come in later, and offers a check in excess of the amount due. He will take such cash as the doctor has on hand. If it is not enough to cover the difference in the amount of the check and the total amount due, he tells the physician to give the remainder to his wife when she comes in.

Upon presentation at the bank, the check is found to be of no value.

It is requested that if this individual puts in appearance anywhere, the local police officials be promptly notified.

Very truly yours,
————, M. D.

Concerning Possibility of Malpractice Suits in Military Services*:

AMERICAN MEDICAL ASSOCIATION
Bureau of Legal Medicine and Legislation

Dear Dr. Kress:

I have received your recent letter with respect to the advisability of physicians who enter military service continuing malpractice insurance.

The editorial discussion of the matter that appeared in *The Journal* for September 13, 1941, is the only reference to the situation that has been published in *The Journal* of the A.M.A. I think that editorial covers the situation adequately. While there is no principle of law with which I am acquainted that exempts a physician in military service from liability for injuries inflicted on service patients due to negligent treatment, it must be admitted that the instances in which physicians in service are sued for malpractice are few and far between. I had some correspondence some time ago about this matter with the Office of the Surgeon General of the Army and my impression as to the infrequency of suits against physicians in service is based on that correspondence. As a matter of fact, the editorial in *The Journal* reflected the information that I received from the Office of the Surgeon General. In addition, I talked the matter over personally with Brigadier General McAfee and he could recall only one instance in which a member of the Medical Corps of the Army was sued for malpractice and that one case never came to trial.

Since there is a possibility of a suit being instituted, I personally believe that a physician in service should carry some type of malpractice protection. The insurance companies, as you know, themselves realize that the possibility of suit being instituted against a physician in service is relatively remote and express that realization by offering protection at a lower premium rate.

Incidentally, there came to my notice just a few days ago a suit that had been instituted against a physician in the United States Public Health Service by a patient who had been treated by the physician in a hospital operated by the Service. The patient in this case was not a member of the military forces but a civilian. This instance does indicate, however, that physicians in the service of the government are not immune from malpractice suits.

To summarize, the situation seems to be about this. Malpractice suits against physicians in military service are extremely rare. If a suit is instituted in a State court it may be removed to a federal court and defense will be supplied by a United States Attorney. If the suit terminates unfavorably to the physician, the obligation of paying the judgment rests on the physician involved, since there is no provision under which the Federal Government may assume any ultimate liability for damages. Since premium rates are being reduced to cover protection of physicians in military service, it is my view that insurance should be carried even though the possibility of suit be remote.

Sincerely yours,
(Signed) J. W. HOLLOWAY, JR.

Concerning Food Requirements of Hospitals in Southern California:

California Medical Association, *Addressed.*

Sirs:

This to call your attention to the following:

An unbalanced distribution, and unbalanced price ceiling and lack of awareness of hospital food requirements has penalized many hospitals in Southern California.

We of the hospital field are urging (1) *food rationing;* (2) an understanding and admission of hospital needs; and (3) an equitable distribution of food allotments for both *public* and *private* hospitals. (O.P.A. regulations now permit public hospitals an edge.) (4) A basic price ceiling for all areas subject to differences of transportation and distribution costs.

Your endorsement would greatly assist us.

(Signed) A. J. WILL.

* See also CALIFORNIA AND WESTERN MEDICINE, October, 1942, on page 278.

* See also CALIFORNIA AND WESTERN MEDICINE, June, 1942, on page 380.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 2, February, 1918

EXCERPTS FROM EDITORIAL NOTES

Annual Meeting at Del Monte.—The annual meeting of the California State Medical Society will be held at the Del Monte Hotel, April 16, 17 and 18, 1918. A program of timely and unusual interest is being prepared. The place and season of the meeting insure a splendid outing for every doctor in attendance. Special announcements and a tentative program will be published next month. It should be the pleasure of every doctor in the State to attend this meeting if he can possibly do so. He is the one who will profit most by attendance. Give the matter serious thought and make your reservations early.

Scientific Program.—A large number of good papers have been secured for the coming meeting at Del Monte and a tentative program will be published in next month's JOURNAL. Naturally in these times various problems connected with the War work are of paramount interest, and accordingly arrangements have been made to have the same presented. There will be sufficient variety to the subjects, however, to insure the presentation of a program of unusual value and interest.

Insurance and the Indemnity Defense Fund.—We have been greatly surprised to learn that some of our members are under the present impression that the Council and Legal Department of the Society have recommended to the members that their insurance be dropped upon joining the Indemnity Defense Fund.

This is erroneous. Neither the Council nor the Legal Department has at any time advocated such a course. On the contrary, our Legal Department has at all times cautioned members who were carrying insurance to continue the insurance, and has recommended that they join the Fund as well; but as to all members who had no insurance, the recommendation has been that they join the Fund. . . .

Therefore, as we have heretofore said, and we thought with sufficient plainness, and which we here repeat, the Society does not advise any member to cancel or give up his insurance upon becoming a member of the Fund, but on the contrary, to continue his insurance and to join the Fund as well. . . .

Editorial Comment.—Why should not every doctor in the United States who is mentally, physically and morally fit, be in the M. R. C.? In the immediate future the Medical Reserve Corps must be immensely augmented; and so as to enable the Surgeon General to have at his command for immediate assignment, as conditions demand, a sufficient number of trained medical officers, let us take the above thought seriously. The German war depends for its success as much upon the medical profession, as upon the combatant forces, and while we do not know that any such intention, as herein suggested, is in the mind of the Surgeon General, it would at least give him the necessary corps of medical officers from which to draw, and would serve the best interests of our country, and the best interests of the medical officers themselves.

(Continued in Front Advertising Section, Page 22)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Some members of the Olson appointed State Board of Chiropractic Examiners have been giving examinations as individuals, charging $100 and pocketing the money. Governor Warren charged at Sacramento yesterday. He disclosed that Attorney General Robert Kenny is investigating the board, with the assistance of the District Attorney at Los Angeles, and that the President of the board has resigned. Replying at his press conference to a question as to whether the board was under scrutiny, the Governor said: 'Since you ask me, the answer is, yes. I am sorry that I cannot give you accurate details. However, it has developed that the chiropractic board has been giving examinations not as a board but as individuals on the board. It also has developed that at least a majority of the board has been charging applicants $100 apiece, the $100 going not to the State but to members of the board. It also has developed that the questions to be asked were put in a position where the applicant could see them beforehand. It also is my information—I cannot say positively—that everyone who took the examination this way and paid the $100, passed. I have not requested any resignations. I am awaiting the action of the attorney general and the district attorney. I am informed that one member of the board admits giving twelve such examinations.' . . . Dr. Charles E. Barrows of Los Angeles, board president, who resigned as a result of the investigation, admitted most of the Governor's charges. But he denied any implication of wrong-doing. He said: 'The board voted last July to do this (individual examinations) to help the war effort, as a patriotic gesture, for those applicants who were ready for their examination and expected to be called into military service before the next examining period. Because there is a lot of work attached to conducting such special examinations, the board authorized the examiner to charge $100; to those who were going into the service and wished to be examined at once and wished to pay $100, that would be the charge—there was nothing compulsory about it.' The $100 was in addition to the $25 fee due the State from each applicant, he said. He estimated that about forty such examinations were given, and that he conducted twenty of them. There was no cribbing, he declared. Dr. Eugene W. Hitchman of San Jose, another member of the board, said he knew nothing of the Governor's charges." (San Francisco *Examiner*, January 20, 1943.)

"Dr. E. W. Merrithew, prominent Martinez physician, is free on bail today after his arrest by California highway patrolmen, on a charge of driving while drunk. . . ." (Oakland *Post-Enquirer*, January 2, 1943.)

"Dr. Vincent P. Carroll, Laguna Beach, and Dr. Glen D. Cayler, Los Angeles, today were reappointed by Governor Culbert L. Olson to the State Board of Osteopathic Examiners. . . ." (Oakland *Post-Enquirer*, December 21, 1942.)

(Continued in Back Advertising Section, Page 36)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

For timely and effective control of Scarlet Fever...

Treatment . . .

SCARLET FEVER STREPTOCOCCUS ANTITOXIN

GLOBULIN *Lederle* MODIFIED

Prevention . . .

SCARLET FEVER STREPTOCOCCUS TOXIN

Lederle

TODAY ANTITOXIN THERAPY may be administered with comparative safety —for both mild and severe scarlet fever. The advanced process of serum refinement by Parfentjev of Lederle Research Laboratories has greatly reduced the incidence of serum sickness[1]. This Globulin-Modified antitoxin usually brings about a sharp drop in temperature and prompt disappearance of symptoms[2,3]. Early administration is advised to thwart the development of complications[4].

In infected, susceptible persons, "Scarlet Fever Streptococcus Antitoxin *Lederle*" may be injected for prophylaxis, and a passive immunity is produced, lasting about two weeks. However, this temporary measure must be followed one week later by active immunization for lasting protection.



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"Scarlet Fever Toxin *Lederle*," for active immunization, is a highly potent and carefully standardized preparation. Complete immunization can be achieved only if a full course of undivided doses is given. By such a method 90-95% of individuals may be rendered Dick-negative, the majority remaining so for as long as 12 years[4].

Some recommend that every child be given a Dick test on entrance to school or an institution, and that a record be kept of the result[5]. Dick-testing and immunization of susceptible individuals is indicated[6] in emergencies such as threat of an epidemic. It is a timely procedure for the large numbers of children who are being moved, in many parts of the country, into over-crowded war-plant areas.

[1]KOJIS, F. G.: Am. J. Dis. Child. 64:93 (July), 1942; 64:143 (Aug.) 1942.
[2]TOP, F. H., and YOUNG, D. C.: J.A.M.A. 117:2056 (Dec. 13) 1941.
[3]PALMER, L.: Kentucky M. J. 40:254 (July) 1942.
[4]MELNICK, T.: Arch. Pediat. 59:90 (Feb.) 1942.
[5]HOYNE, A. L.: Illinois M. J. 81:12 (Jan.) 1942.
[6]THOMPSON, C. G.: Connecticut M. J. 5:736 (Oct.) 1941.

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complete immunization: 5 vials of 650, 2,500, 10,000, 30,000 and 100,000-120,000 S. T. D.
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The contents include sections on wine as a food and on the actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are also discussed. The value of wine as a vehicle for medication is dealt with, and an important section on the contraindications to the use of wine is included. An extensive bibliography is presented for those who may wish to pursue the subject further.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 22)

Los Angeles County Medical Association approves of the following features of a tentative health insurance act, based on one recommended by the Committee of State Social Insurance of the American Association for Labor Legislation. . . .

From an Article on "Metabolism and Disease," by Lorena M. Breed, M. D., Pasadena, California.—The charge has been made in the past that medicine has not kept pace with surgery. This charge, unfortunately, cannot be denied, and the reason, we are forced to admit, has been due, in part at least, to the slow growth in physiology. At the present time, however, the pendulum is swinging the other way. . . .

From an Article on "Practical Value of the Complement Fixation Test for Gonorrhea," by Martin Krotoszyner, M. D., San Francisco.—In a recent article upon the "sero-diagnosis of gonorrhea," attention was directed to certain contradictory features and various serious drawbacks to the accuracy of the test, which are prone to create confusion instead of adding enlightenment in doubtful cases. This being true, it is obvious that the practical value of the test as a diagnostic guide of last resort would be robbed of its most significant value. . . .

From an Article on "Medical Preparedness."—The Board of Trustees of the Medical Society of the State

(Continued on Page 28)

WHO ARE THE MEN BEHIND THE "FACTS"

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FACTS quoted by PHILIP MORRIS are based on studies conducted by recognized authorities whose work is known to the profession... whose findings have been published in leading medical journals.*

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.



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For Information Address: MEDICAL EXECUTIVE OFFICER, 345 West 50th Street, New York City

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

of California [name of California Medical Association at that time], and the Northern and Southern California sections of the medical division of the Council of National Defense, had an important conference on medical preparedness for the War, November 24, 1918, in the Los Angeles Athletic Club as guests of the "Uplifters."

Drs. Harry M. Sherman and Saxton Pope of San Francisco were the chairman and secretary of the Northern Division, and Dr. Henry Sherk of Pasadena and Dr. George H. Kress of Los Angeles with the same offices for the Southern Division.

Dr. Clarence Moore of the Southern Section, made a report on the National Conference of the State Medical Division on National Defense just closed at Chicago.

Dr. Henry H. Sherk has received a commission from Washington to supervise the examination work in connection with the next selective process, and will be assisted by Dr. George H. Kress.

Major A. Jump is to visit California on behalf of the Surgeon General's Office. About 600 commissioned California surgeons are reported to be now with the colors....

From an Article Entitled, "For the Army Nurse Corps."—An army of 1,500 000 men needs 37,509 nurses. There were only 3,800 enrolled December 29, 1917. As an increase of nearly 1,000 per cent is needed some of the requirements for enrolling are being waived.

From an Article on "Compensation for Deaths and Injuries."—The Industrial Accident Commission reported

(Continued on Page 30)

IRRADIATED EVAPORATED MILK

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SPEAKING of "critical materials" in foods, calcium and Vitamin D may well be named. For only when enough milk is consumed regularly are children likely to get adequate calcium. And only when Vitamin D is supplied is there dependable assurance that milk's calcium will be efficiently utilized.

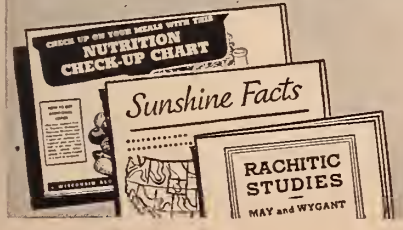
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Let us send you our new "Nutrition Check-Up Chart" listing nutritional values of 225 common foods, "Rachitic Studies" by May and Wygant, and "Sunshine Facts" showing that sunlight is rarely a dependable Vitamin D source. Why not mail the coupon for this important information today?

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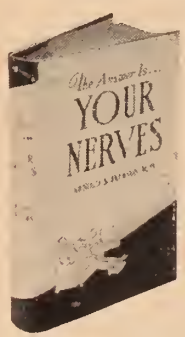
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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

December 30, that during 1917, a total of 657 workmen were killed in California. Medical, surgical and hospital payments amounted to $1,109,072.82, and in addition for death and permanent injury cases, $2,398,232.01, were awarded, making a total in compensation and medical costs $3,507,304.83.

From an Article on "Spinal Cord Changes in Combined Sclerosis," by Walter F. Schaller, M. D., San Francisco.—It is the subacute form of spinal disease usually associated with anemia which I have selected for a study of cord changes and related clinical symptomatology. In our experience this affection is of comparatively frequent occurrence in California, much more often seen than disseminated sclerosis, although not nearly so often as tabes dorsalis. My records show an incidence about equal to that of brain tumor. . . .

From a Special Notice:

Important Notice—Indemnity Defense Fund

Notes are now becoming due.

Do not let your membership lapse.

Each member will be informed ten days in advance of the due date of his note.

The initial assessment for the organization of the Indemnity Defense Fund was fixed at $30.00, one-half to be paid in cash upon subscription, and the balance by note due one year thereafter.

(Continued on Page 34)



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Bequest Forms: Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situate in the County of ———, State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton St., Fresno.



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4. Myelocytes	0.9
5. Myeloblasts	0.4
6. Lymphocytes	10.6
7. Monocytes	2.0
8. Normoblasts	5.0
9. Erythroblasts	1.5
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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

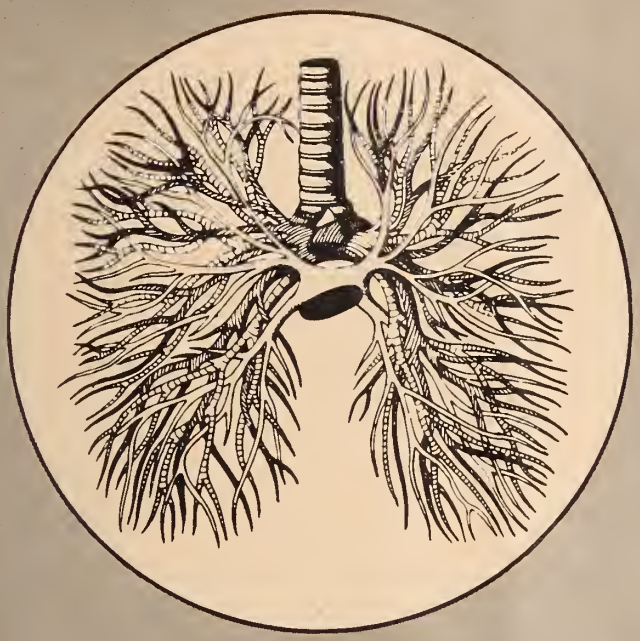
From an Article on "Navy Calls for Binoculars."—The Navy is still in urgent need of binoculars, spy-glasses and telescopes. The use of the submarine has so changed naval warfare that more "eyes" are needed on every ship, in order that a constant and efficient lookout may be maintained. Sextants and chronometers are also urgently required.

Heretofore [prior to 1918], the United States has been obliged to rely almost entirely upon foreign countries for its supply of such articles. These channels of supply are now closed, and as no stock is on hand in this country to meet the present emergency, it has become necessary to appeal to the patriotism of private owners, to furnish "eyes for the Navy."

Several weeks ago, an appeal was made through the daily press, resulting in the receipt of over 3,000 glasses of various kinds, the great majority of which has proven satisfactory for naval use. This number, however, is wholly insufficient, and the Navy needs many thousands more.

All articles should be securely tagged, giving the name and address of the donor, and forwarded by mail or express to the Honorable Franklin D. Roosevelt, Assistant Secretary of the Navy, care of Naval Observatory, Washington, D. C., so that they may be acknowledged by him.

Articles not suitable for naval use will be returned to the sender. Those accepted will be keyed, so that the name and address of the donor will be permanently recorded at the Navy Department, and every effort will be made to return them, with added historic interest, at the termination of the war. It is, of course, impossible to guarantee them against damage or loss.





● From the rare volume, "Tabulae Anatomicae" by Bartholomaei Eustachii, comes this interesting illustration of the bronchi, arteries and veins of the lungs. Published in 1722.

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 102)

"Dr. Cecil Brockhacker of Oakland today was named a member of the State Board of Chiropractic Examiners by Governor Culbert L. Olson, replacing Dr. Franklin Morris." (Oakland *Post-Enquirer,* January 1, 1943.)

"Dr. Nathan S. Housman, San Francisco physician, sentenced to San Quentin prison for perjury and falsification of evidence, was released on parole December 18th and is now under medical treatment in San Francisco, it was revealed yesterday. . . ." (San Francisco *Examiner,* January 5, 1943.)

"Jacob Gloeckler, Denair chiropractor arrested Friday by the F.B.I. as one of the conspirators in an alleged seditious plot engineered by Mankind United, was in the county jail at Modesto today awaiting transfer to the custody of a U. S. Marshal. . . ." (Turlock *Journal,* December 15, 1942.)

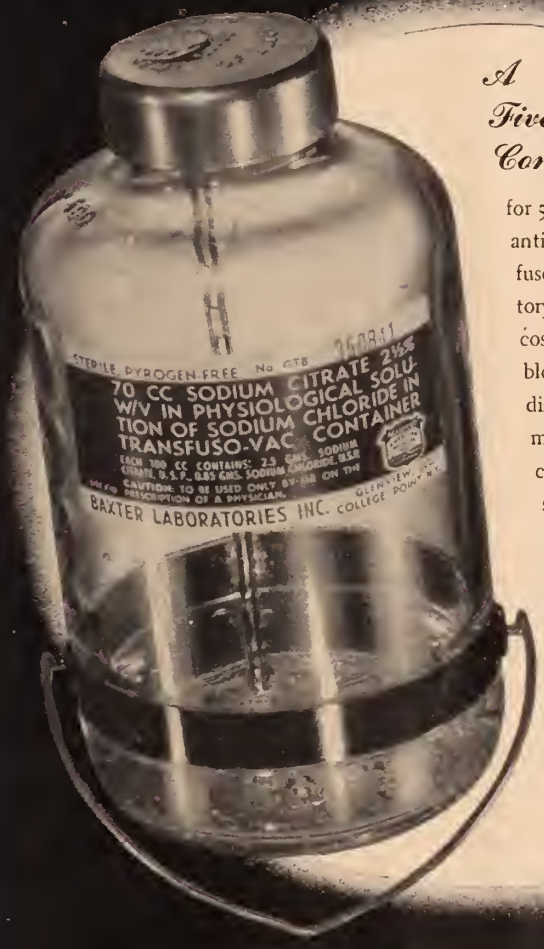
"The names of a San Francisco physician and his wife, as well as those of six other Bay area persons, are on a new list of individuals ordered excluded from the Western Defense Command area as 'dangerous or potentially dangerous' to America at war, it was revealed yesterday. The list, announced by the Army's Wartime Civil Control headquarters here, includes Dr. Arthur Sonnenberg of 3030 Pacific Avenue, and his wife, Elizabeth Marie. Doctor Sonnenberg, who has been on the staff of one of San Francisco's major hospitals, had been

(Continued on Page 38)

Milestones in 7 1941 *Medical History*

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

under surveillance by the Federal Bureau of Investigation (F.B.I.) several times since Pearl Harbor, it was learned yesterday. . . . On yesterday's exclusion list were Dr. Fred Linnenbuerger of Lodi. . . . From Lodi it was learned yesterday that the 'Doctor' Linnenbuerger on yesterday's exclusion list had been a practicing chiropractor in that community since last April." (San Francisco *Examiner*, January 9, 1943.)

"Mrs. Anna B. Brown, convicted on December 10th of performing illegal operations, was today sentenced by Superior Judge Frank C. Collier to five years in prison, suspended on the provisions that she spend one year in the county jail, serve four years probation and quit practicing forever her profession of chiropractic." (Press dispatch dated Pasadena, January 11, printed in the Los Angeles *Examiner*, January 12, 1943.)

"Arthur Osborne Phillips, 48, the 'bogus' doctor who fooled Government officials and a Chico hospital, was sentenced to serve five years in a Federal penitentiary after pleading guilty to three of four counts of obtaining money from a U. S. Government agency through fraudulent claims." (San Francisco *Commercial News*, December 11, 1942.)

"Dr. Karl J. Weberg, chiropractor, of 897 North Fair Oaks Avenue, today was held to answer on a charge of

(Continued on Page 40)



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

performing an illegal operation on an aircraft worker. He is at liberty on $1000 bond pending his Superior Court trial. The case was brought to the attention of the district attorney's office when the asserted victim was taken to the Orange County Hospital." (Pasadena *Star-News*, December 17, 1942.) (Previous entries, July, August, September, 1926; April, 1936; February, 1938.)

"Dismissal of Dr. Carlyle M. Pearce, physician and surgeon at the Sonoma State Home, Eldridge, on charge of 'drunkenness on duty' and 'failure of good behaviour,' was asked in a petition filed with the State Personnel Board. Dr. F. O. Butler, acting director of institutions, who signed the affidavit, charged that Dr. Pearce came on duty November 20th under the influence of liquor and attempted to set the fractured leg of an inmate. On November 23rd, Dr. Butler alleged, Dr. Pearce was unable to perform his duties because he had been drinking." (Sonoma *Index-Tribune*, December 11, 1942.)

"Reginald T. King turned out yesterday to be a Burbank railway employee instead of a doctor, F.B.I. agents said when they arrested him for impersonation. They said he had dolled himself up in an army uniform, posed as an officer of the medical corps, went lecturing at a high school, assumed the privileges of a doctor in a hospital, attended medical conferences and was very generally accepted. But somebody happened to meet him on the street in civilian clothes, got suspicious, called the F.B.I. He is held under $500 bail." (Los Angeles *Daily News*, January 15, 1943.) The Board of Medical Examiners has quite a violator file on Reginald Theodore King, who first came to our attention in 1925.



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Tells of Simple Way to Treat Nail Puncture Wounds of Foot

Method Described by Navy Surgeon Avoids Probing, Laying Open, Drainage and the Injection of an Antiseptic Solution

A simple plan of treatment for nail puncture wounds of the foot is described in *The Journal of the American Medical Association* for May 30, by Fred H. Bowen, M. D., Lieutenant (j.g.), U. S. Naval Reserve, New River, N. C., who says that a total of 661 such wounds were treated by the method with no deaths or tetanus.

Pointing out that there is a wide diversity of opinion in medical literature concerning the proper treatment of such wounds of the foot, Dr. Bowen says that "most authors advocate probing the wound, laying it open, injecting an antiseptic solution . . . and instituting some form of drainage. It is my opinion that such treatment is unnecessary, painful and harmful and that it is followed by prolonged disability and at times by a painful . . . scar. Foreign bodies are not often carried deeply into the foot by a nail but they lie in the dermis (skin) or just beneath it. . . ."

He says that he has demonstrated that nails (6 to 20 penny) are wiped clean in the first ¼ inch of the wound.

In dealing with cases of nail puncture wounds incurred by laborers in the construction of the United States Naval Air Station at Jacksonville, Fla., he says, the following simple plan of treatment was used: The foot was soaked for fifteen to thirty minutes in hot water to which liniment of soft soap or a small quantity of a solution of cresol was added. The foot was dried carefully, and an area about 2 to 3 inches in diameter around the wound was painted with tincture of mercresin. The top layer of the skin was cut away around the wound. This exposed the foreign matter (usually sand, rarely particles of sock, leather, rust, rubber or concrete), which could then be easily removed. A dry dressing was applied, and 1,500 units of tetanus antitoxin was given. If the wound was caused by a nail larger than a 10 penny, the patient was told not to work for at least one or two days, but if a nail of lesser diameter was involved he returned at once to work.

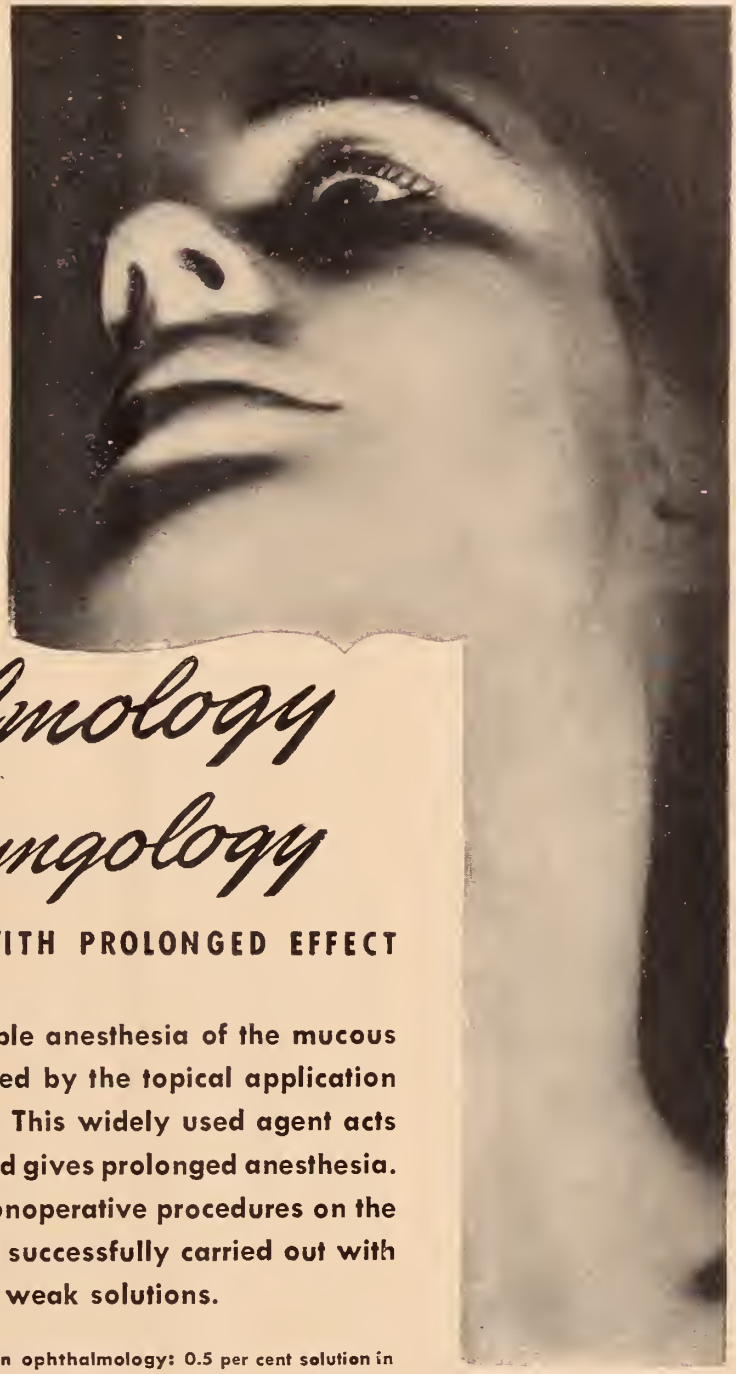
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Preliminary Report on Rheumatic Fever in Los Angeles.—The Los Angeles City Health Department recently reminded the physicians of this city that just one year ago the California State Board of Public Health made rheumatic fever a reportable disease. The reminder states,—"Statistical data pertaining to the incidence of this disease are decidedly meager and it was hoped that by making the disease reportable in California a clearer picture of rheumatic fever as it exists in this state might be obtained.

"For the first eleven months of this year there have been 72 cases of rheumatic fever reported to the City Health Department. Although the disease is considered to be more prevalent in the late spring and early fall, the cases reported to us have been quite evenly distributed throughout the year. It has been suggested that the incidence of rheumatic fever tends to parallel that of scarlet fever. We have been unable to demonstrate any such correlation between these two diseases in Los Angeles.

"Scarlet fever is primarily a disease of early childhood. Most cases occur between the ages of 5 years and 8 years." An analysis of the age distribution of cases reported to the Health Department indicates that rheumatic fever in Los Angeles attacks an older age group: the average age of our cases was 20 years, the median, 16 years. It should be emphasized, however, that the age distribution of our cases may be misleading. Inasmuch as this is the first year of reporting, it is possible that we have received a relatively high percentage of old cases or of 2nd or 3rd relapses reported as original attacks. It will be interesting to see if this older age distribution is repeated next year.

(Continued on Page 45)



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(Continued from Page 44)

"We realize that the total number of cases reported (72) is too small to warrant the drawing of any fast conclusions. They would seem to indicate, however, that rheumatic fever in Los Angeles is relatively evenly distributed throughout the year and that a relatively older age group (with respect to the Eastern U. S.) is affected."

Vitamin Films in Color.—During the past year the three 16mm. silent motion pictures in color, describing certain vitamin deficiency diseases, which were made available by Eli Lilly and Company, Indianapolis, for showing before medical groups under sponsorship of a physician, have been in continuous demand. One film deals with deficiency of thiamine chloride (beri beri), another with nicotinic acid deficiency (pellagra), and the third with ariboflavinosis. To meet increasingly frequent demands for the films, additional new prints have been placed in circulation and are now ready for loan. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication. They do not contain advertising of any description, nor is the name of Eli Lilly and Company mentioned.

The films were made at the Nutrition Clinic of the University of Cincinnati at the Hillman Hospital, Birmingham, Alabama, where studies were initiated in 1935, under the joint auspices of the Department of Internal Medicine of the University of Cincinnati and the University Hospitals of Cleveland. Subsequently, these investigations became a coöperative project between the

(Continued on Page 46)

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Departments of Medicine of the University of Cincinnati and the University of Alabama, and the Department of Preventive Medicine and Public Health of the University of Texas.

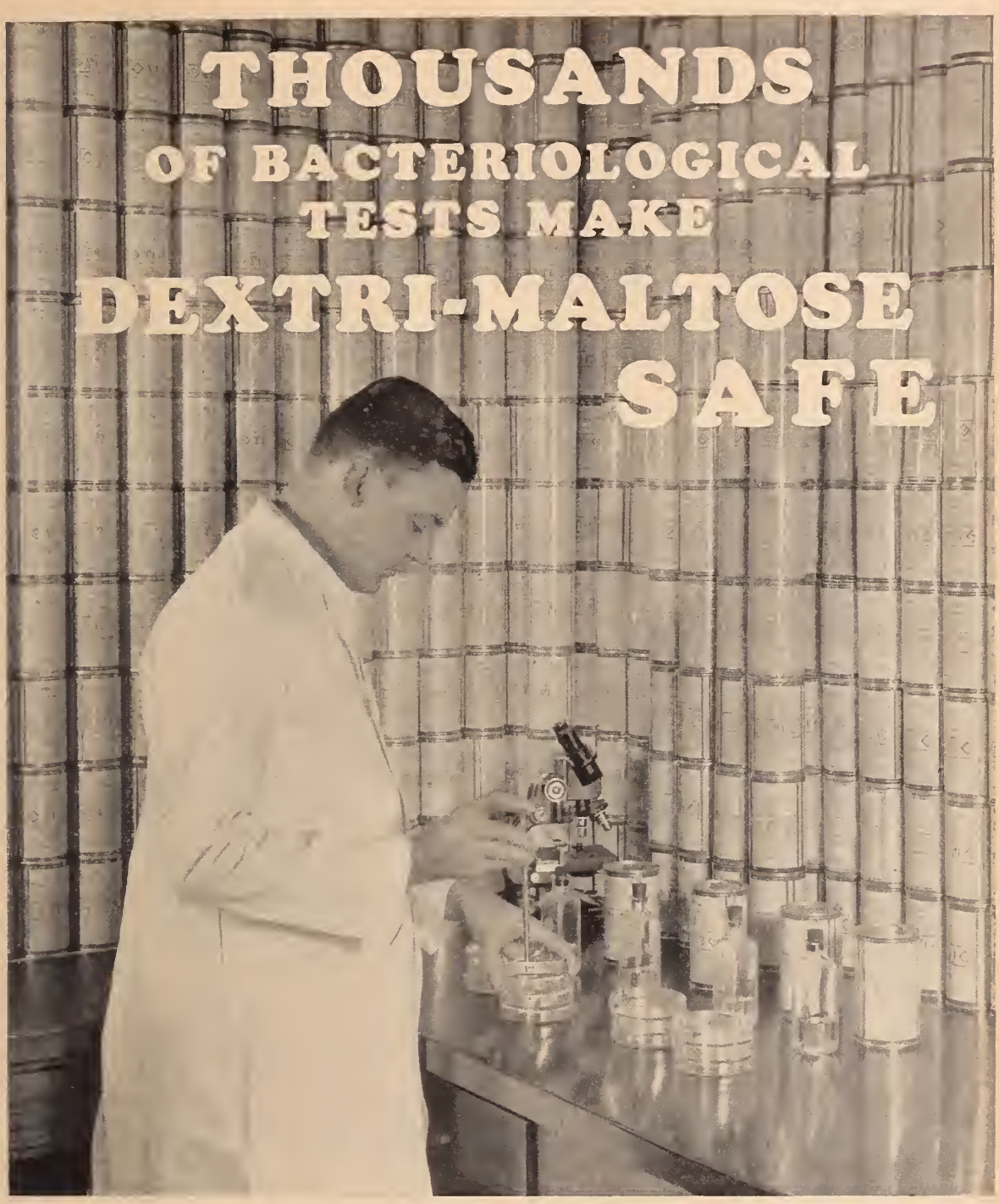
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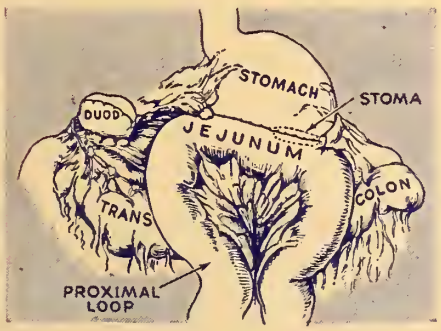
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1. *Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J.; and Wigodsky, H. S.;* Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.
2. *Marshall, S. F., and Devine, J. W. Jr.;* Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

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Editor—George H. Kress, 450 Sutter Street, Room 2004, San Francisco.

Executive Secretary — John Hunton, 450 Sutter Street, Room 2004, San Francisco.

General Counsel—Hartley F. Peart, Room 1800, 111 Sutter Street, San Francisco.

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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

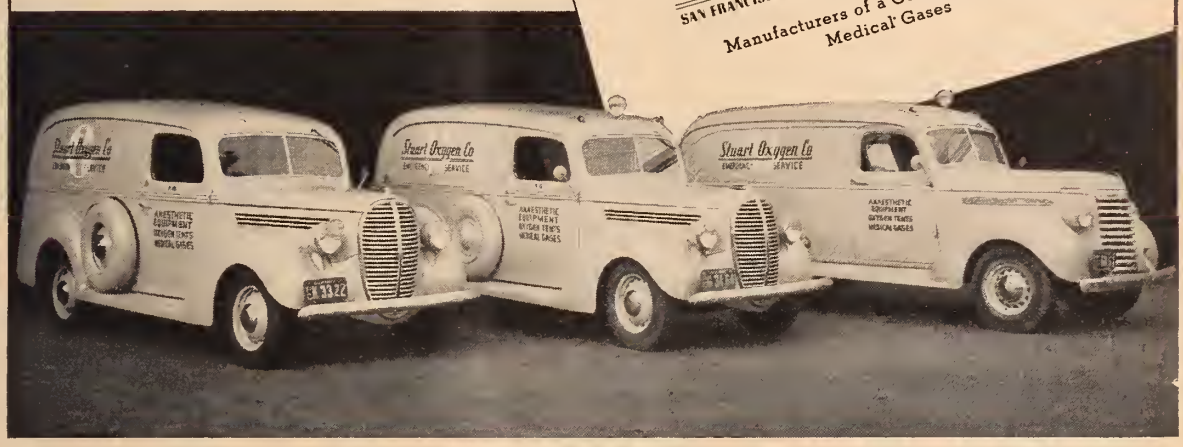
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(Continued on Page 5)

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2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, Philip Hodgkin, Box 1178, El Centro.
Secretary, Henry Forcher, Calexico.
Meeting, ***Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.***

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

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Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

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Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

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President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

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President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
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Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. Don Rolph, 640 National Ave., National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

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President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, 1009 Morro, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie, 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
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Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

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President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, O. T. Wood, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 H Street, Marysville.
Secretary, Joseph H. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

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(Continued from Page 3)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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Hospital Service of California, 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

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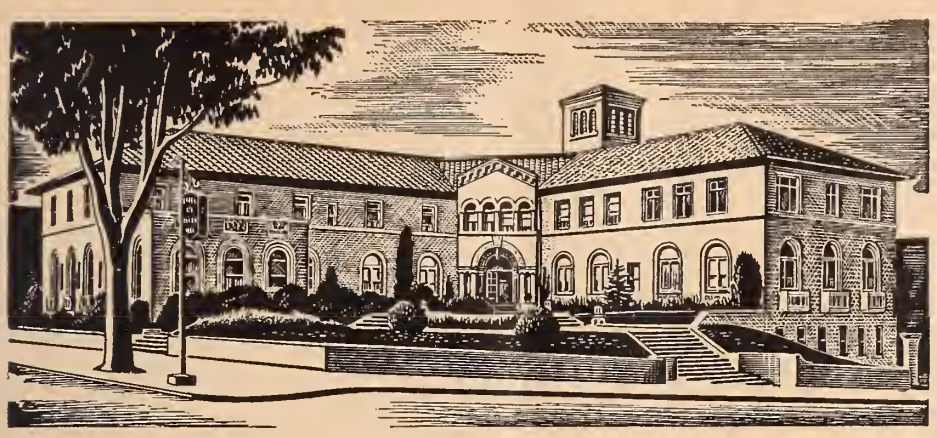
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Endoscopic Prostatic Surgery. By Roger W. Barnes, M.S., M.D., F.A.C.S., Professor of Clinical Urology, College of Medical Evangelists; Chief of Urology Service, White Memorial Hospital and Out-Patient Clinic; Senior Attending Surgeon, Los Angeles County Hospital; Consulting Urologist, Glendale Sanitarium Hospital, Glendale; Harriman Jones Clinic Hospital, Long Beach; Southern Pacific Company, Associated Oil Company, Los Angeles Railway Company, and Los Angeles County Farm. Cloth. Pp. 232, with 104 illustrations. St. Louis: The C. V. Mosby Company, 1943.

Fractures of the Jaws and Other Facial Bones. By Glenn Major, B.S., A.M. (in Pathology), M.S. (in Experimental Surgery), Ph.D. (in Surgery), D.D.S., M.D., F.A.C.S. Pittsburgh; with Chapters on Radiographic Technique, by Lester M. J. Freedman, B.S., M.D., formerly Assistant Radiologist, Department of Diagnostic Roentgenology; now Acting Director, Department of Radioation Therapy, the Western Pennsylvania Hospital, Pittsburgh; and War Aspects of Jaw Fractures, by Arthur Dick, D.D.S., M.D., Major, Medical Corps, Army of the United States. Cloth. Pp. 446, with 225 illustrations. St. Louis: The C. V. Mosby Company, 1943.

The Sight Saver. By C. J. Gerling. Cloth. Price $2.00. Pp. 202. New York: Harvest House, 1943.

Therapeutics of Infancy and Childhood. Edited by Harry R. Litchfield, M.D., F.A.C.P., Lecturer in Pediatrics, Postgraduate Medical Education, Kings County Medical Society—Long Island College of Medicine; Attending Pediatrician, Beth-El Hospital, Brooklyn Women's

(Continued on Page 10)

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Hospital, Brooklyn Thoracic Hospital; Chief of Pediatrics, Watkins Street Dispensary, Brooklyn, New York, and Leon H. Dembo, M.D., Visiting Pediatrician, St. Luke's and St. Ann's Hospitals, Cleveland, Ohio. Containing 117 contributions in four volumes, with a desk index. Profusely illustrated. Philadelphia: F. A. Davis Company, 1942.

The 1942 Year Book of the Eye, Ear, Nose and Throat. The Eye, by Louis Bothman, M.D., Senior Attending Ophthalmologist, St. Luke's Hospital, Chicago; formerly Clinical Professor of Ophthalmology, University of Chicago. **The Ear, Nose and Throat,** by Samuel J. Crowe, M.D., Professor of Otology, Rhinology and Laryngology, Johns Hopkins University; with the collaboration of Elmer W. Hagens, M.D., Assistant Professor of Otolaryngology, Northwestern University Medical School; Member Attending Staff, Wesley Memorial Hospital, Chicago. Cloth. Pp. 640. Chicago: The Year Book Publishers, 1942.

How to Learn and Advance. By Samuel Kahn, M.D., Ph.D. Formerly on the Faculties of Georgetown and New York Universities; Chief Psychiatrist, U. S. Induction Boards for the States of New Jersey and Delaware; Author of Sing Sing Criminals, Psychological and Neurological Definitions, Etc. Cloth. Price $2.00. Pp. 196. New York: The Alpha Press, 1942.

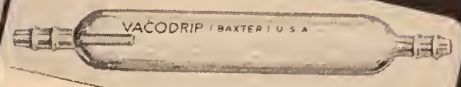
Essentials of Gynecology. By Willard R. Cooke, M.D., F.A.C.S., Professor and Head of the Department of Obstetrics and Gynecology, University of Texas. Cloth. Price $6.50. Pp. 474, with 197 illustrations, including 10 in color. Philadelphia, Montreal, London: L. B. Lippincott Company, 1943.

Diseases of the Breast. By Charles F. Geschickter, M.A., M.D., Lieut. Commander, Medical Corps, United States Naval Reserve, Director of the Francis P. Garvan Cancer Research Laboratory, Pathologist, St. Agnes Hospital, Baltimore. With a Special Section on Treatment,

(Continued on Page 14)

Milestones in Medical History

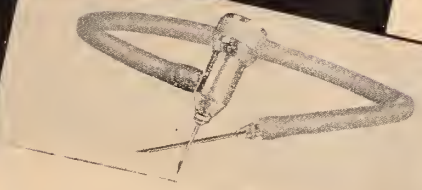
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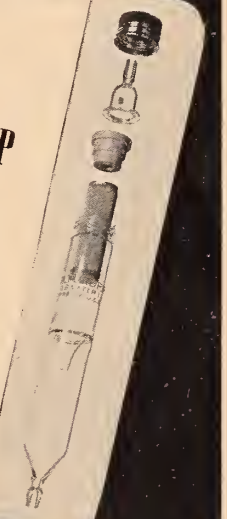
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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in collaboration with Murray M. Copeland, A.B., M.D., F.A.C.S., Instructor in Surgery, Johns Hopkins Medical School, Visiting Surgeon and Assistant Oncologist, University Hospital, University of Maryland Medical School, Visiting Oncologist, Baltimore City Hospitals. Cloth. Price $10.00. Pp. 829, with 593 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Pushkin. A collection of Articles and Essays on the Great Russian Poet, A. S. Pushkin. Cloth. Pp. 188, with illustrations. Moscow: The U.S.S.R. Society for Cultural Relations with Foreign Countries, 1939.

BOOK REVIEWS

The Principles and Practice of Medicine. Originally written by Sir William Osler, Bart, M.D., F.R.C.P., F.R.S. By Henry A. Christian, A.M., M.D., LL.D., Hon. Sc.D., Hon. F.R.C.P. (Can.), F.A.C.P. Hersey Professor of the Theory and Practice of Physic, Emeritus, Harvard University; Physician in Chief, Emeritus, Peter Bent Brigham Hospital; Visiting Physician, Beth Israel Hospital, Boston. Fourteenth Semicentennial (1892-1942) Edition. Leather. Pp. 1475. New York: D. Appleton-Century Company, Incorporated, 1942.

The first edition of Osler's Practice of Medicine was written fifty years ago by William Osler, while Physician-in-Chief of the Johns Hopkins Hospital in Baltimore. Revisions were made by him while Professor of Medicine at Johns Hopkins and later on while Regius Professor of Medicine at Oxford, assisted after 1912 by Thomas McCrae. On the death of Sir William Osler in 1919 the work was continued by McCrae, then Professor of Medicine at Jefferson Medical School in Philadelphia,

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 14)

who revised the 10th, 11th and 12th editions. In 1938 the 13th edition appeared under the present editor [Henry A. Christian], then Hersey Professor of the Theory and Practice of Physic at Harvard University.

For a span of fifty years, 1892 to 1942, this volume has epitomized the practice of medicine as modified from edition to edition by the guiding hand of an editor, who as teacher and practitioner had gathered from the writings of many their medical wisdom and had interpreted it to succeeding generations of students and practitioners in the light of a personal clinical experience gained from ward visits, office and consultation practice and from the teaching of medical students. At the Montreal General Hospital and McGill University, at the Philadelphia General Hospital and the University of Pennsylvania, at the Johns Hopkins Hospital and University, at Oxford University, at the Jefferson Hospital and Medical School and at the Peter Bent Brigham Hospital and Harvard University in succession the editors carried on their work. Since Osler began his clinical work at McGill in Montreal seventy-five years have elapsed, and in the sundry locations of the medical work of the successive editors almost every kind of disease has presented itself for personal study and treatment. Thus the clinical descriptions in this volume with very few exceptions have been based on a personal observation steadily expanded in succeeding editions as more examples of the particular disease have been studied. . . .

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(Continued on Page 22)



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[1] Fabricant, M.D.: "Nasal Medication," Williams and Wilkins Company, October, 1942.

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BOOK REVIEWS

(Continued from Page 18)

The study of disease goes forward steadily. As never before is there a need for a text kept up to date. To meet this need this fourteenth edition is being published. . . .

War Medicine. A Symposium, edited by Winfield Scott Pugh, M.D., Commander (MC), U.S.N. Retired. Formerly Surgeon, City Hospital, New York. Cloth. Price $7.50. Pp. 565, illustrated. New York: Philosophical Library, 1942.

This short review of military surgery does not include services rendered in base hospitals where equipment, surroundings, and absence of danger closely simulate conditions found in any modern civilian hospital. In the combat zone the medical officer immediately finds himself confronted with an environment and a class of traumatic lesions more or less foreign to him. He is no longer able to choose his own conditions but has to make the best of those in which his lot is cast. . . .

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The authors state:

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(Continued in Back Advertising Section, Page 26)

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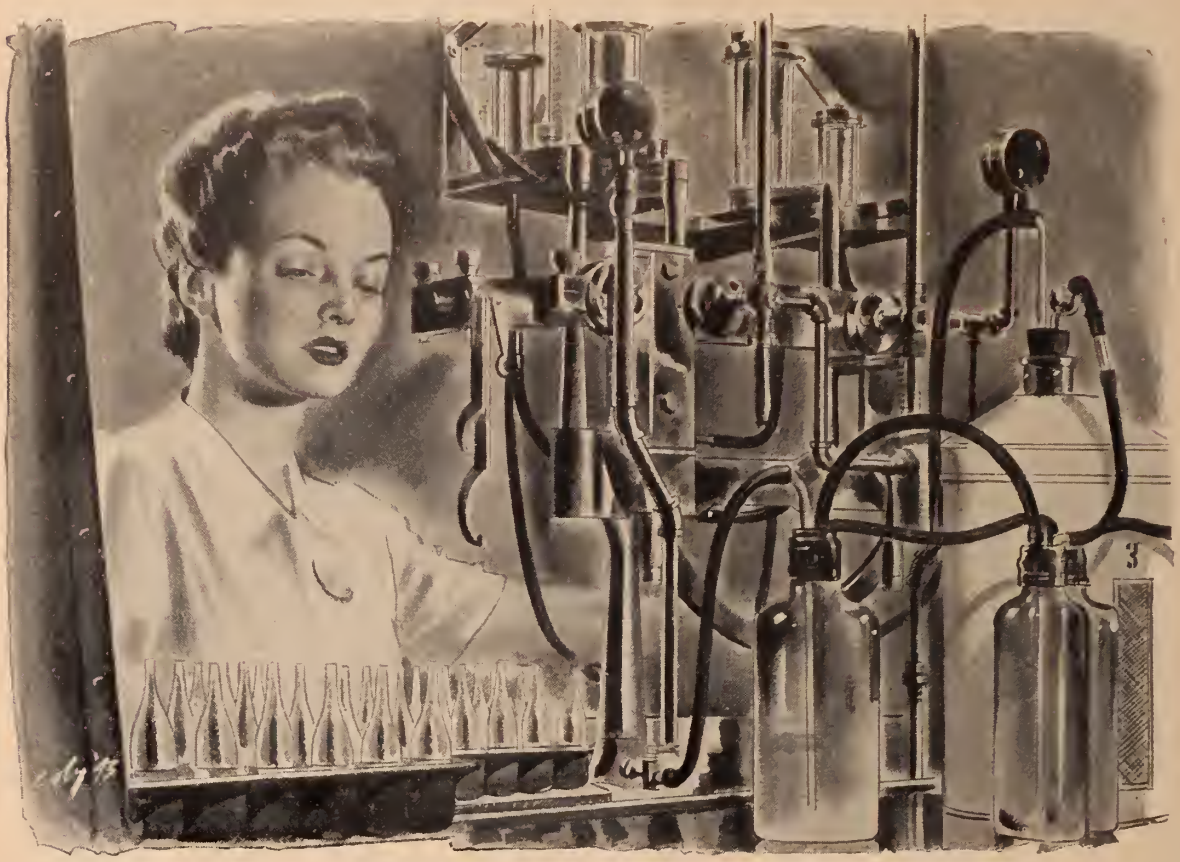
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F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

"DOCTOR SHORTAGE"—WITH REFERENCE TO CALIFORNIA

"Shortage," a Word of Increasing Use.—"Shortage," defined in the dictionary as "a deficiency in quantity," is a word now-a-days heard with increasing frequency in relation to many supposed or real needs of the population of the United States. When used in the term, "Doctor Shortage,"—a caption frequently catching the eyes of readers during perusal of editorials, letters from the people, special and other articles so often appearing in the lay press, it takes on special significance, especially to members of the medical profession. Because, during recent years, so much space has been given in print to voluminous discussion of supposedly "inadequate medical care," the "Doctor Shortage" legend assumes special interest in these wartime days.

Citizens of our own country have become so accustomed to receive a high type of professional care, with hospital and other accessory aids, for the alleviation of their physical and mental ills, that it is now somewhat difficult for many persons to differentiate between essential and non-essential medical service. In other words, it is hard for them to distinguish between care sufficient to safeguard health and life, and that additional supervision that partakes of the nature of what might be called "luxury medicine and care."

Be that as it may, the members of the public will be obliged to accommodate themselves to the new order in regard to medical service, just as they are learning to readjust their habits concerning food, clothing and housing.

* * *

The Pool of Available Physicians for Civilian Practice Approximates 80,000.—With a realistic pool of about 136,000 Doctors of Medicine available for both military and civilian needs,—of whom, by now, more than 40,000 have been inducted into the Armed Services, and with some 11,500 to follow during the current calendar year,—there are left from the total of 136,000 physicians in the available pool, only about 80,000, or so, who can be used in active civilian practice.

Since a total of 176,000 physicians is listed as being in active practice in the United States (when no deductions for incapacity through age or other deficiencies are made)—it follows that the civilian population of our Country will be obliged to get along with about one-half the number of Doctors of Medicine citizens formerly

enjoyed, and,—whether they like it or not,—begin to get accustomed to the new arrangements.

* * *

Increased Work for Physicians.—It naturally follows that the new set-up throws much additional work upon the physicians who yet remain in civilian practice. However, if a clearly outlined educational program is carried through with patients, it may still be possible to prosecute medical work with very fair efficiency and no loss of standards, and meet all fundamental medical practice needs. Of course, in case of widespread epidemic or other catastrophes, the picture will have different hues. But there also, with proper foresight and planning, it should be possible to maintain organization or group effort of kind that will provide essential and basic care, both in amount and quality, sufficient to prevent unnecessary loss of life.

* * *

Questionnaire of C.M.A. Council.—The Council of the California Medical Association recently circularized the component county medical societies regarding doctor shortage problems in their respective communities. It is gratifying to know, while physicians almost everywhere are working harder than in pre-war days,—that the medical needs of the respective communities and areas throughout the State are being met in fairly adequate fashion. Further, that in a few of the places where medical service hardships seemingly do exist, the basic trouble is not so much because of inability of the attending physicians of the district to give proper care to families, but rests rather on other governmental regulations and directives dealing with supplies of gasoline, tires and traffic accessories, which prevent citizens from going to the available physician or physicians. In other words, the hardships due to such factors are being plastered on the medical profession instead of on the governmental agencies not identified with public health activities, who, really, are the blameworthy agencies.

The proponents of some socialized and state medical schemes will no doubt use existing conditions to prove that a larger number of physicians and hospitals are needed. These advocates show their incapacity to see the problem through. The mere fact that standards of public health are being maintained with 80,000 physicians instead of 176,000 Doctors of Medicine in active practice, and when also, fewer hospital beds are available,—owing to taking-over of many civilian hospitals by military authorities,—indicates how far astray the exponents of theoretical expositions on medical care have wandered from the realistic approach.

As before stated, it is gratifying to learn,—in spite of the fact that 40,000 to 50,000 of our younger Doctors of Medicine are now with the Armed Forces,—that the maintenance of health and conservation of life of our fellow citizens throughout the Union has been and is being maintained in quite satisfactory manner. As actual needs arise, means will undoubtedly be found to meet the situations.

ANNUAL SESSION IN LOS ANGELES—SUNDAY, MAY 2 AND MONDAY, MAY 3, 1943

Important to Make Transportation and Hotel Reservations.—A two-day, streamlined annual session, to be held in Los Angeles on Sunday, May 2nd and Monday, May 3rd, with Hotel Biltmore as headquarters, received editorial comment in the December issue of California and Western Medicine.

The general plan then outlined will be carried through. All indications point to a successful gathering. The attendance should be good because the Los Angeles County Medical Association, with a membership of some 2,826 physicians in itself is sufficiently large to make possible an excellent registration.

Sunday, for the first time, has been selected as the opening day of an annual session, since it will be more convenient for physicians to arrange their work for a brief two-day vacation over Saturday, Sunday and Monday, than during other days of the week.

In the January number of California and Western Medicine, on pages 32-34, a preliminary list of hotels with rates, and of transportation schedules, was given. It is important for all who wish to travel or to make hotel reservations that these be arranged well in advance. *Do not neglect to make these reservations.*

* * *

Skeleton Form of Scientific Program.—The scheduled arrangement of the program as finally decided upon, contemplates three general meetings: a meeting on Sunday morning, especially for reports of officers and topics related to organized medicine, such as medical service and hospitalization problems; on Sunday afternoon, medical and surgical topics; and on Monday morning, medical and surgical subjects, and clinical-pathological conference.

Concerning the phases of medicine and surgery upon which emphasis will be placed, the Committee on Scientific Work has agreed to stress the following:

1. Communicable Diseases (tropical and diseases such as typhus, influenza, and malaria).
2. Practical Points in Civilian Disaster Relief (with consideration of problems actually found important in disaster):—burns, shock, and other major points in disaster management.
3. Nutrition Problems, in relation to food shortage and other conditions.
4. New Problems in Wartime Industry.

Guest speakers, whose names are well known in medical literature have been invited. The "Pre-Convention Bulletin" which appears in the April issue of California and Western Medicine, will give detailed information.

The twelve scientific sections will hold their group meetings on Monday afternoon, at which time papers and discussions on pertinent topics, and election of section officers, will take place.

Medical and surgical films will be shown in the Music Room (during the times of the general meetings) for members who have special interest therein. Hour of the appearance of each of the films will be scheduled. No general scientific exhibits will be displayed this year, nor will there be a presentation of technical or commercial exhibits. (Members who have made medical films are urged to inform the Association Secretary.)

The meeting room arrangements in the Hotel Biltmore are excellent. In fact, they are as good or better than those at Hotel Del Monte, even with the recent assembly room additions.

The "Dinner to the President" will be held on Sunday evening, in the celebrated Biltmore Bowl. It is believed that there will be a large attendance of members and their ladies, since in these wartime, rationing days, a "dinner out" becomes a function of special interest. In due course, complete information concerning the program and other arrangements will appear in the "Pre-Convention Bulletin" in the April number of CALIFORNIA AND WESTERN MEDICINE.

Members who doubt the advisability of even a brief, two-day annual session may care to read what the *New York State Journal of Medicine* recently stated concerning its own medical meeting at a time when our Country is at war. Quotation follows:

> This year's annual session "will be the second such meeting in wartime and should be attended by all who can possibly be there; yes, and even by those who for some reason think they can't! We know it will be difficult—use of cars restricted, train travel onerous, bicycles rationed, too far to walk, limited hitching and stable facilities for horses, too expensive to fly, canal boats and barges not running on regular schedules. Conditions were worse in grandfather's day, but he came in large numbers, and so will you.
>
> "Much has happened since we met last spring, much that you will want to hear about: war medicine and surgery, new treatments, new instruments, changes in methods of practice, what the profession in various parts of the State and elsewhere is doing and planning to meet its particular needs. . . .
>
> "Make your plans now to come. Later we shall tell you more of the scientific program, but just now we ask you to note the dates and to lay your plans to come."

Sunday, May 2nd and Monday, May 3rd, 1943, in Los Angeles, at Hotel Biltmore—write down the dates *now* in your engagement book. Then watch CALIFORNIA AND WESTERN MEDICINE for further announcements.

CALIFORNIA'S MINERAL SPRINGS: JOINT RESOLUTION BY THE CALIFORNIA LEGISLATURE URGING THEIR USE

Purpose of the Joint Resolution.—In this issue appears a joint resolution, unanimously approved by both the Senate and Assembly of the present California Legislature, in which the Federal military and other authorities are urged to consider the advantages which would accrue to patients, if one or more military hospitals were erected in some of the mineral spring areas of the State. (For text of resolution, see page 137.)

In calling attention to the joint resolution, it may be stated that physicians of California were apparently more interested in the value of mineral springs a half century and more ago, than they seem to have been during recent years.

* * *

Some References to California Literature.—In checking the literature, the following comments by Doctor A. Rice on the subject of mineral springs and resorts were found in the *Southern California Practitioner* of January, 1887:

1. Physicians, individually or in committee, should make careful analysis of our mineral waters.

2. The medicinal value of the waters should be tested by clinical investigation, and studies upon patients, and the conclusions arrived at given to the profession.

3. If the waters are found to possess marked medicinal merit, physicians should interest themselves in the development of the springs and the improvement of bath-houses and apparatus.

4. Physicians, in sending patients to a mineral spring, should be most careful to select the proper water, and should send, with the patient, his history and the diagnosis of his disease, for the benefit of the physician at the bath.

5. Patients at our mineral spas should be placed under more rigid medical discipline, and more attention should be paid to their habits of living.

6. The social life at our watering-places should be placed on a more wholesome basis.

Joseph Pomeroy Widney, founder of the *Southern California Practitioner*, and motivating spirit in the group of founders of the Los Angeles County Medical Association, who passed on several years ago at the advanced age of 96, contributed numerous articles of like nature.

In the San Francisco Bay Region, among authors who have written on the same subject, reference may be made to the late Doctor Winslow Anderson, whose book, "Mineral Springs and Health Resorts of California," a volume of 384 pages, was brought off by the pioneer Bancroft Press in 1892, winning special recognition in the "Prize Essay and Annual Prize Contest of the Medical Society of the State of California," and being so awarded on April 20, 1889. Its entire contents are devoted to chemical and other analyses and descriptive matter of the many mineral springs existing in California.

Another article from the *Southern California Practitioner* appeared in the December, 1887, issue, its author being J. W. Robertson of the Napa Asylum. A brief excerpt therefrom follows:

> California has but recently attracted the attention of sanitarians. This tardy recognition was partly due to its isolation, partly to the fact that the Argonauts looked not at the sky, but at the earth, and cared nothing for scenery, climate or a pure atmosphere. The Coast belt contained no gold, therefore they ignored it. Southern California, where now bloom perennial orange groves and the rarest exotics, they pronounced a desert scarcely able

to support a meager growth of sage brush and cactus,—a fit habitation for the coyote. Only recently has the fact been borne in mind that something is to be found more precious than gold, and from all over the world thousands of invalids flock here. Our people have not realized that California has a cosmopolitan climate adapted to all diseases that can possibly be benefited by change of air; that within its borders are to be found the altitude of the Alps, the scenery of Switzerland, the fruits of the tropics, numerous mineral springs which equal in value and are more healthfully situated than are those of the Eastern United States or Europe; the pure air of the Colorado Highlands and the winter climate of Florida; and that it is a nice question to always properly decide on that location best situated to relieve their particular disease. People do not always choose wisely.

* * *

Article by Henry E. Sigerist of Johns Hopkins.—More recently, in the *Bulletin of the History of Medicine* (Vol. XI, No. 2, February, 1942), the well-known Henry E. Sigerist, M. D., a member of the Johns Hopkins University School of Medicine, discussed the curative aspects of mineral springs in general and those of America in particular. So pertinent are the comments, that liberty is taken to reprint some of his opinions:

To the European physician who comes to America it is very striking to find what little use this country is making of its mineral springs. The situation is so totally different from that which prevails in Europe that it calls for an analysis. . . .

Medicinal springs and their curative powers are mentioned by ancient and mediaeval medical writers. . . .

The European spas have been used for over 2,000 years. Medical theories changed. . . .

But whatever the theories were, patients for over 2,000 years went to the spas, bathed in their waters, drank them and found relief. Every medical theory was used to explain the effect of medicinal waters. The explanations changed, but there were always results. In every century patients were benefited by their cures. . . .

It is very unscientific to deny the experience of 2,000 years merely because we have no ready-made theory that explains all phenomena in every detail. It would have been foolish to deny the existence of lightning because electricity was not yet known. Experience has preceded science in medicine more than once. Our most valuable drugs, quinine, digitalis, opium, mercury and many others were given for centuries, long before pharmacology was able to explain their action. Oskar Baudisch has very pertinently shown how similar the situation was with regard to heliotherapy. Sunlight was used as a healing agent for centuries. Rickets were treated with ultraviolet rays. To "scientific physicians" this was a mere superstition—until the vitamins were discovered and it was found that sunlight changes the ergosterol of the skin into vitamin D. Chemistry until recently was gross chemistry; microchemistry is in its infancy still, and we are beginning to realize that a few molecules of a chemical compound can cause definite biological reactions. . . .

I would like to make a strong plea for the development of our American health resorts. We need them, not because European resorts are unavailable at the moment. There is no reason why our patients should have to go to Europe for such treatments. We need them because the chronic diseases, the diseases of mature and old age are in the foreground, our major health problems today. We shall need them badly after the war, not only for the veterans of the armed forces, but also for the veterans of labor. . . .

* * *

California's Mineral Springs Deserve Promotion.—The 400 or more mineral springs of California are among the great natural resources of the State, still awaiting development. The California State Chamber of Commerce, during the last four years has placed the subject on the program of one of its Sections, the writer having presented three addresses on the topic. Two years ago, a "League for the Development of California's Mineral Springs" was formed, to aid in the work. It was hoped that a movement such as the Redwood League might be started, through which some of California's major forest attractions were saved from destruction.

This year, with the 55th Legislature in session, it has been possible to bring about the adoption of the joint resolution which appears elsewhere in this issue. A perusal of the resolution indicates its purpose:—to urge the constituted Federal authorities to use one or more of California's mineral springs areas as reservations on which could be erected hospital structures, so that spa therapy of scientific standards may be made available to wounded and sick soldiers and sailors, whose convalescence would thereby be promoted and expedited.

If California's mineral springs can so be developed with spa environments in accord with the best experience and standards, their fame will bring thousands of additional visitors to the State, to the benefit not only of the patients, but to the material and other interests of the Commonwealth.

California medicine would profit greatly through the establishment of such institutions. It is hoped that increasing interest will be given to the subject by physicians.

EDITORIAL COMMENT†

ANTIMALARIAL VACCINE AND SERUM THERAPY

An important contribution to the basic theory of antimalarial immunity is contained in a study of the efficacy of prophylactic injections of nonviable malarial sporozoites, currently reported by Russell and Mohan,[1] of the Pasteur Institute. Coonoor, India.

The animals used in this study were domestic fowls inoculated with Plasmodium gallinaceum. Each fowl was infected by the bites of two Aëdes albopictus mosquitoes, which had ingested an infective blood meal 15 days previously. The insects were maintained at 80° F and 80 per cent humidity during the 15-day period. All normal

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

birds thus bitten developed parasites in the blood after a prepatent period of from 8 to 10 days, the average incubation period being 9.1 days. The percentage of infected red blood cells averaged less than 1 per cent at this time, increasing to 11 per cent by the 12th day, to 35 per cent by the 14th day, and to 62 per cent on the day of death, death usually taking place by the 20th day. The mortality rate varied from 40 to 100 per cent in the different groups, averaging 55.4 per cent in all groups. In nonfatal cases the parasite count usually reached its maximum between the 12th and 18th day, and then decreased, the blood becoming free of parasites by the 24th day.

Nonviable vaccines were prepared from ground dried thoraces of mosquitoes that had taken an infective blood meal 15 days previously. Each fowl received five intravenous injections at 5-day intervals of a saline suspension of 40 emulsified thoraces. In each case the agglutinating titer of the fowl's serum for homologous sporozoite suspensions rose to an average of 1:100,000 by the day of experimental inoculation. Following the bites of two infected mosquitoes, parasites appeared in the blood of all vaccinated birds. Less than 1 per cent counts were recorded on the 8th and 10th day, increasing to from 5 to 13 per cent infection by the 12th to 14th day. In 70 per cent of the vaccinated fowls the count then decreased, full recovery being recorded by the 20th day. In 30 per cent of the vaccinated birds the count continued to rise to about 60 per cent by the 14th day, death occurring on the following day. The average maximum count in all vaccinated birds was 20 per cent, as contrasted with a 43 per cent average in the nonvaccinated controls. The mortality rate of 30 per cent is also in contrast with the control mortality rate of 55.4 per cent. Both mortality and severity of the infection were thus reduced one-half as a result of prophylactic immunization. In no case, however, was the infection prevented by the sporozoite vaccine nor the incubation period appreciably prolonged.

Supplementing their study of active immunization, Russell tested the efficiency of a passive transfer of acquired malarial immunity. A group of normal fowls were each given 7 daily intraperitoneal injections of 1 c.c. of pooled serum from a number of fowls having chronic malaria due to homologous plasmodium. After the third immune serum injection, each fowl was bitten by two infective mosquitoes. All contracted malaria. The average latent period was 8.2 days, as contrasted with 9.1 days in the control birds. The mortality rate was reduced to 25 per cent.

Tests were also made of the possibility of combining both active and passive immunization. A number of fowls were given routine doses of the sporozoite vaccine, and afterwards injected intraperitoneally or intravenously with pooled serum from fowls having chronic homologous malarial infections. The pooled serums had an average sporozoite agglutinating titer of 1:180,000. Each fowl was afterwards bitten by two infectious mosquitoes. The combined data from all series thus tested showed an average mortality rate of less than 10 per cent. In no cases, however, was the disease prevented by this combined immunization nor the latent period appreciably prolonged.

The fact that in no case in Russell's multiple tests was malarial infection prevented by active, passive or combined immunization, suggests that immunoprophylaxis is of little or no promise in the epidemiological control of malaria. Although both severity and mortality were reduced as a result of active or passive immunization, the clinical results were not superior to those obtained with routine antimalarial drugs. The work is being continued largely for its theoretic interests.

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AVITAMINOTIC HYPERTENSION

A challenging new theory of the mechanism of renal hypertension is suggested by Calder,[1] of the Clayton Foundation for Research, Duke University, in his recent demonstration of the causal relationship between persistent arterial hypertension and vitamin B_2 deficiency.

The discovery by Goldblatt[2] that experimental renal ischemia is followed by persistent arterial hypertension has led to a generally accepted theory as to the mechanism of renal hypertension. According to this theory,[3, 4] incomplete oxidation of amino acids in the ischemic kidney leads to the formation of intermediary pressor-amines, which in the normal kidney are completely oxidized to nonpressor end-products. The effective etiologic mechanism, therefore, is a diminished oxidative capacity of the kidney. If so, intermediary pressor-amines should also be formed as a result of any other factors reducing the oxidative capacity of the kidney parenchyma. It is generally accepted that the vitamin B complex furnishes essential components of several respiratory enzymic systems. It would logically follow, therefore, that vitamin B deficiency might cause a sufficient decrease in the oxidative capacity of the kidney to give rise to the same hypertensive amines.

To test this possibility Calder maintained numerous groups of rats on various B deficiency diets, and recorded the weekly changes in blood pressure, the experiments usually extending over a period of from 2 to 4 months. In most cases the blood pressure was estimated by the Williams[5] indirect method. In a few animals the pressure was also determined directly by inserting a cannula into the abdominal aorta. The two methods gave practically identical results.

Among Calder's most significant data are his studies of the effects of partial or complete deprivation of "vitamin B_2 complex." This he de-

fines as "the heat-stable fraction of the total vitaman B complex." Starting with an average blood pressure of 115 mm. Hg, a group of 50 rats showed a rise to 145 mm. Hg blood pressure when partially or completely deprived of the vitamin B_2 fractions. This rise was reached by the end of the second week and was maintained for 16 weeks (end of experiment). At any time during this period the blood pressure could be reduced to normal by restoring the heat-stable vitamin B factors to the diet. Significantly, partial B_2 deficiencies were followed by higher rises in blood pressure than those produced by a complete deficiency. This Calder explains as probably due to the debilitating effects of total deprivation of B_2 factors.

Even more pronounced debilitating effects were noted in several groups of rats which received no vitamin B whatsoever. These showed a slight (10 mm.) rise in blood pressure during the first week of complete B avitaminosis, followed by a fall in arterial pressure to below normal by the end of the second week. When this hypertensive deficiency diet was fortified by the addition of thiamin, there was a rapid rise in blood pressure to 142 mm. Hg by the end of two weeks.

Incidentally it was noted by the Duke University physiologist that his experimental hypertensive rats were very intolerant of ether, a few whiffs administered for the purpose of deepening the anesthetic effects of nembutal often proving fatal. The hypertensive rats were also unusually susceptible to shock.

While Calder's results are in seeming confirmation of his postulated avitaminotic reduction in the oxidative capacity of the kidneys, he is careful to emphasize the possibility that other metabolic abnormalities may conceivably play a part. Detailed studies of kidney functions will be necessary to prove the suggested avitamotic renal theory. From a practical point of view, however, demonstration that the hypersensitive state may be symptomatic of "vitamin B_2 complex" deficiency has numerous important clinical applications. Other types of deficiency are now under investigation in Duke University.

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FELINE INFLUENZA IN MAN

Recently several clinicians have reported a possible epidemiologic connection between certain atypical pneumonias in man and a respiratory tract infection of cats, variously designated as nasal catarrh, influenza or distemper. Evidence that these two diseases are due to the same virus is currently reported by Baker[1] of the Rockefeller Institute. Suspensions of lungs from cats showing typical influenza symptoms with pneumonia were inoculated intranasally into mice. The mice became sick in the first passage, and many of them died in from 3 to 5 days. Necropsy showed a definite pneumonia with more than half the lung involved. Mouse-to-mouse serial passage increased the virulence of the infectious agent to a point where death occurred in 2 to 3 days, following intranasal inoculation. Control tests from normal cats and uninoculated mice were invariably negative.

Cultures from the lungs of naturally infected cats and of artificially infected mice showed few bacteria and were frequently negative. The infective agent, transferred to the yolk sac of 5-day incubated eggs, usually killed the embryo in from 2 to 3 days. When suspensions of the inoculated yolk sac membranes were given intranasally to normal kittens a typical disease was produced, which was readily transferred by contact to other kittens. All attempts failed to demonstrate a cultivable bacterium from the yolk sac, suggesting that the infectious agent is presumably a virus. Attempts to pass the agent through Berkfeld filters gave irregular results. Sections of the yolk sac membranes and smears from lungs of infected mice revealed numerous elementary bodies similar to those of psittacosis. High speed centrifugation concentrated much of the infectious agent in the sediment, suggestive evidence that the observed elementary bodies are carriers of the etiological agent.

Complement fixation tests were made using this concentrate as antigen. Sera obtained from cats before infection failed to fix complement with this antigen. Convalescent cat serums, however, gave strongly positive reactions. Serums drawn from man during the acute and convalescent stages of the atypical pneumonia also fixed complement in relatively high dilution. Most control normal human serums were negative or gave relatively low positive reactions. From this evidence Baker concludes that the respiratory disease in cats is due to a virus that forms elementary bodies and that this virus is the same as (or is closely related to) the one causing some of the so-called atypical pneumonias in man. Further work is in progress.

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While a child is acquiring an education he should be doing things he will have to do while he is earning a living.—H. Ford.

"There are some men who lift the age which they inhabit—till all men walk on higher ground during that lifetime."—Maxwell Anderson.

ORIGINAL ARTICLES

Scientific and General

BRONCHIOGENIC CARCINOMA: THE RÔLE OF BRONCHOSCOPY*

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BY means of the bronchoscope we are able to inspect directly the lumen of the tracheobronchial tree. In many problems of thoracic disease bronchoscopy is an important supplement to other methods of study, particularly the physical and roentgenographic examinations. To look at, to look through, and to look into, might be called the first three commandments for proper intrathoracic diagnosis. Skill is demanded in performing a bronchoscopy; likewise the operator must be able properly to interpret his findings. This predicates a first hand knowledge of tracheobronchial anatomy and pathology. Bronchoscopists whose experience is limited to the occasional extraction of foreign bodies often lack this ability. In skilled hands endoscopic procedures are of only passing discomfort to the patient and the hazard is minimal.

In the thorough study of any patient suspected of having pulmonary cancer, bronchoscopy inevitably follows the history, physical examination, laboratory and roentgenographic studies.[1] Even with negative roentgenographic findings bronchoscopy is indicated if the patient continues to cough, wheeze or expectorate blood-streaked sputum.

The bronchoscopic picture of carcinoma varies widely. Perhaps most usual is the soft, fungating, exuberant type which partially or completely fills the bronchial lumen. The growth may be polypoid or sessile. Pseudo-membranous exudates are common. In color, the tissue varies from greyish-yellow to deep red depending upon the amount of necrosis or vascularity. There is moderate bleeding on manipulation. Shallow hemorrhagic ulcers ("ulcerating carcinoma") with raised, indurated borders are occasionally seen. With proximal extramural extension a bronchial stenosis may be present which interferes with adequate visualization of the primary growth.

It must be remembered that there can be no positive diagnosis of cancer until it is proven under the microscope. A biopsy, therefore, must be procured. Tissue may be obtained by several means. In most cases the writer prefers foreign body cup-forceps by which tissue can be scalped or teased off the main mass. There is less bleeding than when using the usual type of basket forceps which have a cutting edge. The latter may be necessary when the tissue is firm. When very flattened growths are encountered, or the actual endobronchial lesion is beyond a stenosis, it may be advantageous to obtain tissue by endoscopic curettage.[2] Long, sharp curettes have been successfully employed in a number of cases when ordinary forceps failed. An attempt always should be made to secure sufficient tissue for examination, but gentleness is imperative. A carelessly performed biopsy increases the danger of severe hemorrhage or perforation of the bronchial wall. Should the *microscopic* evidence of carcinoma be inconclusive, further bronchoscopic biopsies are demanded within a short time. A positive biopsy should eventually be obtained in approximately three out of four cases.

Special problems arise in bronchoscopic diagnosis. Tumors arising in the upper lobar bronchus ordinarily cannot be seen unless they protrude into the stem bronchus. Here, a retrograde telescope passed through the bronchoscope is used to advantage. Subsequent angulation of the lobar bronchus can be produced by pneumothorax which may facilitate direct vision and biopsy. Lower lobe shadows should be carefully localized by frontal stereoscopic and lateral roentgenograms. Should the lesion then *not* be visualized at bronchoscopy, careful blind probing with curette or cup forceps may be productive of tissue. Small strings of bloody exudate and sputum should be aspirated into a specimen bottle and fixed for paraffin section. A biplane fluoroscope also has been used for localization at the operating table.[3]

Differential diagnosis is necessary from the following diseases. Pulmonary tuberculosis occasionally is complicated by granulomatous or stenotic bronchial lesions. In general, tuberculous granulation tissue is more avascular than cancer. The lesion nearly always continues into a lobar bronchus. If the sputum has been negative for tubercle bacilli prior to bronchoscopy but tuberculosis is suspected later, a postbronchoscopic, 48-hour sputum specimen should be subjected to further search. The possibility of a bronchial foreign body always should be kept in mind. Nonspecific pneumonitis, bronchiectasis and abscess may result in bronchial granulation tissue. It is flattened or polypoid, dull red in color and vascular. It is often localized in the stem bronchus opposite the lobar orifice which drains the infected area in the lung. There will be spontaneous regression as the pulmonary infection improves. Tumors of the adenoma type are partially to completely obstructive, round or oval in shape and of a reddish color. The surface may be smooth, having the appearance of a capsule. Usually there is excessive bleeding when a biopsy is taken.

It is generally agreed that the best chance for cure in primary carcinoma of the lung lies in radical surgery, that is, total removal of the lung.

* Presented as part of the State Cancer Committee Symposium on Primary Carcinoma of the Lung at the annual meeting of the California Medical Association, Del Monte, California, May 5-8, 1941.

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Lobectomy is almost never adequate and should be condemned as an operative choice. One of the most important functions of bronchoscopy is to aid in the determination of operability. For this reason it is advisable for the thoracic surgeon to perform his own bronchoscopic examinations. He should decide by personal inspection whether or not pulmonary resection should be attempted. As the bronchoscope is passed the vocal cords are examined first. The presence of recurrent laryngeal paralysis usually means that neoplastic infiltration has occurred outside the bronchial wall, rendering a successful excision (pneumonectomy) very unlikely. The main bifurcation of the trachea (carina) normally presents as a sharp or slightly blunted edge and has an elastic feel when pressed with tip of the bronchoscope. If the carina is widened or fixed, it strongly suggests the presence of metastases in the adjacent mediastinal lymph nodes. This finding would contraindicate operation. The bronchial wall proximal to the neoplasm may show changes. Induration, stenosis, fixation or deformity means the presence of submucosal or extrabronchial neoplastic encroachment. The surgeon-bronchoscopist must estimate whether it will be possible to resect the bronchus far enough proximally to get beyond the growth. Should there be induration or distortion of the lower lateral tracheal wall it is probable that the lung cannot be successfully removed even though the visible endobronchial growth is some centimeters distal in the stem bronchus. If there is any question of esophageal involvement, an esophagoscopy can easily be performed at the conclusion of the bronchoscopic examination.

Definitive treatment of bronchial carcinoma through the bronchoscope has not proven satisfactory. It now seems probable that in earlier reports of cures by endobronchial excision, the lesion in question was a bronchial adenoma and not carcinoma. When pneumonectomy is contraindicated, palliative endobronchial radiation therapy can be tried. Radon seeds may be implanted directly into the growth through the bronchoscope. In the writer's experience this has been followed by temporary improvement in two cases. Radium may also be introduced through the bronchoscope for a given period by means of a small cylindrical "bomb."

Finally, the bronchoscope is very effective in improving pulmonary drainage when chronic pulmonary infection exists distal to an obstructing neoplasm. Exuberant tissue is removed, the lumen gently dilated, retained secretions are aspirated and the mucosa shrunken. It has been our repeated experience that the establishment of a more adequate air-way renders the patient a much better risk for major surgery. Toxicity, cough, and fever are greatly reduced, there is improved appetite and the patient's sense of general well-being is considerably heightened.

SUMMARY

1. Bronchoscopy with biopsy is the most important single procedure for the *positive* diagnosis of primary cancer of the lung. In most cases microscopic proof of malignancy can be obtained in no other way. Since bronchiogenic carcinoma can be cured by radical surgery (total pneumonectomy) it is imperative that the diagnosis be established as early as possible.

2. In skillful hands bronchoscopy is of passing discomfort only and carries little hazard for the patient. The examination must always be strongly urged when the suspicion of a bronchial neoplasm arises.

3. It is of great importance that the thoracic surgeon be able to perform his own bronchoscopies and estimate for himself the question of operability.

4. In differential diagnosis bronchial cancer must be distinguished from tuberculous bronchitis, local foreign-body reaction, the bronchial sequelae of pulmonary suppuration, benign tumors (especially adenoma) and nonspecific bronchostenosis.

5. Attempts at total bronchoscopic excision and endobronchial radiation therapy have failed as curative measures in bronchiogenic carcinoma.

6. Bronchoscopy establishes more adequate drainage for the pulmonary suppuration which so often occurs distal to an obstructing neoplasm. This is of great value in reducing the operative hazard when pneumonectomy is contemplated.

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ECTOPIC PREGNANCY*

A REVIEW OF SIXTY-FIVE CASES OCCURRING IN A GENERAL HOSPITAL OVER AN EIGHT-YEAR PERIOD

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AN ectopic pregnancy is any pregnancy occurring outside of the uterus. The pregnancy may be located in the tube, in the ovary, or in the abdominal cavity, and even rare instances of cervical pregnancy have been recorded.

The occurrence of this condition has sometimes been the cause of very dramatic episodes in the lives of both patient and physician. And since none of us sees a great many patients with this disease, and since the condition is one in which most of us have at least some interest, it might be well to outline briefly some of its more important characteristics.

* Read before the Section on Obstetrics and Gynecology, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

In regard to the etiology of the condition, there are three generally accepted causes: first, obstruction of the tube, either from within or without; second, anomalies of the tube, such as polyps, diverticula, or accessory ostia; and third, external migration of the ovum—that is—the passage of the egg from the ovary on one side, to the tube on the opposite side.

Ectopic pregnancy may terminate in one of several ways. It may terminate in the early death of the fetus, with complete resorption and without harm to the patient. Or, the pregnancy may end in the early death of the fetus with the formation of a so-called tubal blood mole, in which there is only a blood clot in the tube, and, when it is observed microscopically, only occasional shadows of chorionic villi are seen. The pregnancy may also terminate in tubal abortion, in which case the products of conception are expelled from the fimbriated end of the tube. Or, finally, the pregnancy may terminate in the rupture of the tube. In rare instances, following tubal rupture, the placenta may attach itself to adjacent structures, and the pregnancy then develops as an abdominal one.

The symptoms and signs of ectopic pregnancy may be briefly outlined as follows. There is almost invariably a history of irregular menstrual bleeding, with or without a short period of amenorrhea. Nausea, breast changes, and the other indefinite signs of pregnancy are usually present. Pelvic pain is present, although it may be slight. When tubal rupture or tubal abortion occurs, the pain becomes much more severe. A tender mass can generally be detected in one or the other adnexal regions. In cases where massive hemorrhage has occurred there are the usual signs of shock, and the white blood count is elevated. Abdominal rigidity and the other signs of peritoneal irritation are fairly constant findings. There is one other sign which is often overlooked, namely shoulder-pain. This sign is present in a considerable number of patients, and is, of course, due to the presence of blood beneath the diaphragm.

From an historical standpoint it is interesting to note that the first operation for an abdominal pregnancy was performed in the year 1500, when Jacob Nufer, a swine-spayer, operated upon his own wife. Similar operations were occasionally performed in the next 300 years, but it was not until 1883, just fifty-nine years ago, that Lawson Tait performed the first laparotomy for a ruptured tubal pregnancy. Tait's first patient died, and he was roundly criticized; but in spite of this he operated upon forty more patients with ruptured tubal pregnancy, and only one died. This record compares very favorably with modern results, as the figures presented in this paper will show.

SOURCE MATERIAL

This study is based upon all of the cases of ectopic pregnancy which were operated upon at the Huntington Memorial Hospital in Pasadena, between June 1, 1933 and June 1, 1941. In all there were a total of sixty-five cases and these sixty-five patients were cared for by twenty different surgeons. In all of these patients the ectopic pregnancy was a tubal one. In thirty-one patients the tube had ruptured, in twenty-two patients tubal abortion had occurred, and in the twelve remaining patients the tubal pregnancy was unruptured, and there was no sign of tubal abortion.

Table 1.—*Diagnosis*

	Correct		*Diagnosis Suspected*		*Incorrect*	
	Cases	*Per Cent*	*Cases*	*Per Cent*	*Cases*	*Per Cent*
Ruptured (31 cases)	17	54.8	7	22.6	7	22.6
Tubal Abortion (22 cases)	9	40.5	10	45.4	3	14.1
Unruptured (12 cases)	4	33.3	1	8.3	7	58.4
Total	30	46.1	18	27.7	17	26.1

The percentage of correct diagnoses in these cases is shown in Table 1. It will be noted that the number of correct diagnoses is considerably higher in those patients who had a ruptured tubal pregnancy or tubal abortion, than it was in those who had an unruptured tubal pregnancy. This is to be expected, since the symptoms are much more acute in the patient with hemoperitoneum. In 27.7 per cent of the total number of cases the diagnosis of ectopic pregnancy was mentioned as one of two or more possibilities. These are the cases listed in the column labeled "Diagnosis Suspected." In 26.1 per cent of the patients the correct diagnosis was not even mentioned as a possibility.

Table 2.—*Incorrect Diagnoses*

	Ruptured	*Tubal Abortion*	*Unruptured*
Acute Appendicitis	6	2	0
Chronic Appendicitis	0	1	3
Ovarian Cyst	2	2	2
Ovarian Cyst with twisted pedicle	2	1	0
Acute Salpingitis	2	1	0
Chronic Salpingitis	1	0	2
Uterine Fibroid	2	0	0
Intestinal Obstruction	1	0	0
Incomplete Abortion	0	1	3

Table 2 consists of a list of the various conditions which were confused with ectopic pregnancy. It is apparent that acute and chronic appendicitis head the list, while ovarian cyst, with or without twisted pedicle, is in second place.

So far as the etiology of the condition is concerned, two factors were considered in this study. First, an attempt was made to correlate the incidence of ectopic pregnancy with the parity of the patient. In this series 43 per cent occurred in primiparae, 44.6 per cent occurred in multiparae, and in the remaining 12.3 per cent the number of pregnancies was not recorded in the history. Since this is approximately the same ratio that obtained on the maternity ward during the same period, it

is apparent that in this rather small series the parity of the patient does not seem to be an important etiological factor. The second factor studied was the history of previous pelvic infection. In this series 13 patients, or 20 per cent of the total, gave a history of some type of pelvic or intraabdominal infection. Six patients gave a history of gonorrhea, six gave a history of puerperal or general peritoneal infection, and one had a tuberculous salpingitis. In this series at least, previous infection appears to have been a very definite factor in causing the abnormal pregnancy.

Table 3.—*Pain*

	Absent	*Intermittent*	*Constant*	*Total*
Ruptured	1	13	17	31
Tubal Abortion	3	15	4	22
Unruptured	0	8	4	12

Irregular Menstrual Bleeding

	Absent	*Present*	*Not Recorded*
Ruptured	3	28	0
Tubal Abortion	4	15	3
Unruptured	0	11	1

Table 4.—*Nausea and Vomiting*

	Present	*Absent*	*Not Recorded*
Ruptured	7	23	1
Tubal Abortion	1	19	2
Unruptured	0	10	2

Shoulder-Pain

	Number of Cases
Ruptured	5 (16.1%)
Tubal Abortion	3 (13.6%)
Unruptured	0

Tables 3 and 4 show the occurrence of the more common symptoms in this series. It will be noted that pain and irregular menstrual bleeding were present in the very great majority of cases. It is also interesting to note that those patients who had a ruptured tubal pregnancy were apt to have a constant type of pain, whereas in those who had a tubal abortion the type of pain most commonly complained of was intermittent, or crampy. This is apparently due to the peristaltic action of the tube in attempting to expel the ovum. Nausea and vomiting were rather uncommon symptoms. In eight of these patients shoulder-pain was noted. This symptom is probably more common than these figures would indicate, as in many cases no attempt was made to elicit its presence or absence.

Table 5.—*Pelvic Mass*

	Present	*Absent*	*Not Recorded*
Ruptured	16	7	8
Tubal Abortion	12	1	9
Unruptured	8	3	1

Shock

(Systolic pressure below 100 and Pulse over 100)

	Number of Cases
Ruptured	13 (42.0%)
Tubal Abortion	5 (22.7%)
Unruptured	0

Table 5 indicates the chief clinical findings in this series. A definite pelvic mass was discovered in 36 patients, no mass was felt in 11 patients, and, unfortunately, in 18 of these 65 patients, no pelvic or rectal examination was recorded on the chart. In most of these 18 patients a pelvic examination had been performed by the attending surgeon in his office or in the patient's home, but the findings were not recorded on the hospital record by the intern. However, it goes without saying, that any woman subjected to laparotomy for any cause whatever, should first have a careful pelvic or rectal examination. In this series there were 18 patients who showed varying degrees of shock, and, of course, most of them were among those who had actual tubal rupture.

Table 6.—*Surgical Treatment*

	Ruptured	*Tubal Abortion*	*Unruptured*
Salpingectomy	17	10	8
Salpingo-oöphorectomy	11	7	1
Bilateral Salpingectomy	1	4	0
Salpingectomy and Hysterectomy	2	1	1
Incidental Appendectomy	5	8	8
Uterine Suspension	2	1	0
Dilatation and Curettage (Diagnostic)	3	4	4

Table 6 indicates the various surgical procedures carried out on the patients in this series, and it is to this chart that we should pay particular attention. It is obvious from the very nature of ectopic pregnancy that the only essential surgery is either simple unilateral salpingectomy, or occasionally, unilateral salpingo-oöphorectomy. It is apparent from a study of this series that it is common practice to perform a good deal of incidental surgery on these patients. It should be emphasized that numerous authorities have shown that this is a very dangerous practice, and that if it is continued over a long enough time it will invariably result in the death of some patients. The best surgical treatment for patients with ectopic pregnancy is the removal of the affected tube, and the removal of that organ only, in the shortest time possible. And it might also be added that the tube should be removed completely, since, if it is not, another ectopic may occur in the tubal stump.

In this series of sixty-five patients, transfusion was employed in twenty-eight instances. Thirteen of these were autotransfusions. No serious reactions were recorded. The Friedman test was used in nine patients. It was negative in one case sixteen days prior to tubal rupture, and was positive on the day following operation. In the remaining eight cases the test was positive, and was of considerable diagnostic value.

The average hospital stay in this series was thirteen days. There was one serious postoperative complication—a case of intestinal obstruction. The patient made an uneventful recovery after release of the obstruction.

Table 7 shows mortality statistics as given out by various investigators. In Parry's series, pub-

lished in 1876, before the surgical treatment of ectopic pregnancy, the mortality was 77.2 per cent.

Table 7.—*Mortality Statistics*

	Cases	Deaths	Per Cent
Parry (1876) Philadelphia	500	386	77.2
Graffagnino, et al (1922-36)... New Orleans	445	51	11.4
Langman & Goldblatt (1930-36) New York	310	8	2.6
Weil (1931-36) Akron	100	5	5.0
Lisa, Alessi, & Solomon..... New York (1922-39)	115	5	4.3
Schauffler & Wynia (1931-41). Portland	65	2	3.0
Miller (1940) New Orleans	137	3	2.1
Huntington Memorial Hosp.... Pasadena (1933-41)	65	0	0.0

It is apparent that the mortality rate in this condition is gradually decreasing, and it is now somewhere between two and five per cent. In the series reported here there were no deaths, and, while in most instances this was due to prompt treatment and good judgment, yet in some of the cases the survival of the patient must, in all fairness, be attributed entirely to very good luck. And unless some of the unnecessary surgery is eliminated, we will most certainly have some deaths in our next sixty-five cases.

CONCLUSIONS

1. Our percentage of correct diagnoses would be improved if we constantly bore in mind the fact that any woman in the child-bearing age who presents herself with the symptoms of pelvic or abdominal pain, accompanied by irregular menstrual bleeding, may possibly have an ectopic pregnancy.

2. We would also improve our percentage of correct diagnoses if we would invariably perform a careful pelvic or rectal examination on every woman subjected to abdominal surgery.

3. A correct diagnosis would be arrived at more frequently if we made more use of the Friedman test in the less acute cases.

4. Preëxisting pelvic infection is a very definite factor in the production of ectopic pregnancy, but it is by no means the only one.

5. If we are to keep our mortality figures low, we must very carefully avoid all unnecessary surgical procedures.

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URETERAL CALCULUS: ITS MANAGEMENT*

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It has become an established custom for the chairman of each scientific section to deliver an annual address. Fortified by this precedential consideration, and by the fact that all rebuttal is strictly taboo under the circumstances, your Chairman ventures to set forth herein certain opinions with regard to the management of ureteral calculi. Opinions are both justifiable and quite the order of the day in this realm, since palpably no rule of thumb approach nor standardized technique will suffice for universal application. In sooth, the problem of stone management remains a highly individualistic matter from the standpoint of both patient and surgeon alike. Moreover, in solution of this problem, there appears to be no substitute for actual experience.

Any urologist practicing in the Sacramento Valley must soon acquire skill in the management of ureteral calculi because he sees so many. In fact, stone in this area constitutes an overwhelming proportion of all upper urinary tract morbidity. The exact explanation remains controversial. Older men were prone to blame climatic vagaries (the extremely hot days and the cool nights which are responsible for drastic changes in urinary concentration), or possibly the abundance of very hard water in this district. Modern brain trusters, however, with their streamlined etiologic concepts invoke dietary deficiencies, metabolic disorders, colloidal imbalances, obstructive phenomena, parathyroid tendencies, renal trauma and focal infections as more probable causative factors. Whatever the true explanation may be, calculi have always been and still are prolific in the Sacramento Valley, the present upsurge of scientific and quasi-scientific measures for prophylaxis to the contrary notwithstanding.

STONE PREVENTION

This article concerns itself but briefly with methods for stone prevention. Certainly the urine of a stone-former must be checked and double-checked repeatedly for bacteria. Positive identification of the type of organism is important with regard to both treatment and prognosis. The presence of the urea-splitting group constitutes a challenge to therapy and militates for recurrence. Certainly a careful check of the urinary tract (especially intravenous pyelography) is in order to eliminate any deviatory quotient with urinary stasis. Inquiry into dietary habits may be productive, especially as to excessive ingestion of foods rich in calcium phosphate and with regard to prolonged use of any medication. Determinations of the calcium content of the urine should be

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made. A persistent calciuria may connote hyperthyroidism or altered bone metabolism among other factors. Chemical analysis of the stone may prove illuminating from an etiologic standpoint. Fortunately, most common stones contain calcium and phosphorous in varying amounts, and hence are shadowgraphic because of the radiodensity of these elements. A relative appraisal of the stone's composition can be obtained from the roentgenologic study alone. The intensity of the shadow, the sharpness of outline, the general appearance, the homogeneity or lack of homogeneity in density, the contour and structural arrangement are all suggestive. The "feathery" calcium oxalate deposition, the lamellated phosphatic stone and the peculiar wax-like cystine formation need no introduction to the modern Zadig. Few stones are completely radiolucent (notably uric acid crystals), and these which are usually small in size may betray their presence by increased density in the renal shadow during excretory urography before other diagnostic methods are employed.

Despite chemical erudition, newer pathologic teachings, relevant theoretical prolixity, and advanced physiologic concepts, many phases of stone prevention still remain enigmatic. Moreover, in spite of these advances, corresponding clinical accomplishments seem woefully lacking —at least to the practical soul or iconoclast. Aside from appropriate measures to relieve urinary stasis and eliminate infection, the hard-headed surgeon has had little faith in the ertswhile sallies of the theorist to dispatch the unknown culprit through alteration of the urinary pH, dietary prestidigitation or vitamin administration. Memories of Don Quixote and the windmills linger, therapeutic lances are friable and stones often reform or increase in size despite an "all-out" effort to the contrary. Innovations—newer methods for stone prevention—come and go with almost monotonous regularity, but surely at this time no Promethean unguent is as yet discernible upon the horizon. Only yesterday the vitamin concept seemed most plausible and already the rôle of A deficiency has been disparaged in the scales of clinical application. In the light of our present knowledge it seems almost fitting to relegate this subject of stone prophylaxis to the inhabitants of the Island of Lanterns—so ably described by Rabelais in his celebrated satire. Such a conclusion, however, intends no aspersion upon current research and valuable clinical studies to the end of prophylaxis.

GENERAL CONSIDERATIONS

Effective management of a ureteral calculus depends upon comprehensive study of the patient as well as of the stone. Only in this way can a strategic approach be planned. The size, shape, number and position of the stone or stones are all important. Other things being equal, a stone without spicules or facets, but regular in contour and small in size, should offer the least difficulty to passage. Many stones are obviously too large to pass, as indicated directly by the roentgenologic examination. With regard to stones of lesser magnitude, size alone does not determine the degree of motility or progress. The presence of several stones on a given side or bilateral involvement but complicates the original problem. A stone fixed elsewhere than at one of the three anatomic points of ureteral constriction (i.e., at the uretero-pelvic juncture, the pelvic brim and the entrance into the bladder), suggests thereby pathologic change or abnormal narrowing in the respective area. Stones are more often impacted in the prevesical spindle (1 to 4 cm. above the ureteral orifice) than elsewhere. The greatest barrier to transit is usually encountered at a point just where the ureter dips into the bladder, and here the stone is prone to lodge and progress ceases. The intramural segment of the ureter is the least distensible, but once the stone enters therein, transit is usually assured. Dilatation or thinning of the ureter above a stone bespeaks chronicity and agurs against expeditious passage.

All factors relative to the patient himself must be weighed and appraised in choice of the technical approach. The condition of the corresponding kidney and the status of the opposite kidney are vitally important. The presence of urinary infection, chills, fever, sepsis, hemorrhage, uremia, referred gastro-intestinal symptoms, agonizing pain without relief or evidence of progress may necessitate a shift in operative attack. Likewise a tight urethral stricture or an obstructing prostate may preclude instrumental manipulation or render the latter inadvisable because of potential untoward reactions.

TECHNICAL CONSIDERATIONS

It was Agur in the book of Proverbs who tabulated four things hard to be known, to wit: the way of an eagle in the air; the way of a serpent upon a rock; the way of a ship in the midst of the sea; and the way of a man with a maid. To this list the humble urologist might add the way of a stone in the ureter. For surely nothing is more unpredictable or whimsical than the behavior of a calculus in the ureter. At times a tiny stone impacted in the pelvic segment constitutes such a Nemesis to patient and surgeon alike as to mandate ureterolithotomy. Again, a very large stone promptly responds to the slighest manipulative effort with a "pop" into the bladder. Nor is it unusual for a tightly lodged stone of some size, after several apparently futile manipulative attempts, to deliver spontaneously an hour or so before surgery is undertaken. Hence, it cannot be considered remiss in certain instances (when the stone is small and in the absence of infection and subjective symptoms) "to trust to the whirlwind and the current," even as Pantagruel did his ship in quest of the empire of Whimdom. In fine, to play percentages and adopt a watchful waiting attitude for an indeterminate interval

pending spontaneous passage of the stone is not always an impractical procedure.

Explanation for this freakish behavior of ureteral calculi, while not quickly forthcoming, hinges at least in part upon the ureter's mechanical ability to express the stone. To this purpose it appears poorly adapted since the lumen is small, the walls thin, the musculature not overly developed and the whole structure keenly susceptible to reflexes which may be more adverse than helpful under the stimulus of the foreign body. Whosoever, while performing cystoscopy, has the misfortune to snap off a ureteral bougie or catheter, so that the broken end protrudes slightly from the ureteral orifice, will likely receive an impressive demonstration of ureteral reflex, a potentiality not soon forgotten. Twice the author has experienced this mishap and both times, much to his chagrin and vexation, the bougie quickly disappeared from sight and agilely ascended the ureter. Needless to say surgical removal was necessary. Just why these reflexes must be so contrary under the circumstances remains something of a mystery, and one willingly left to the physiologist for explanation.

Aside from those stones which pass spontaneously, perhaps 65 to 75 per cent of the remainder can be assisted by instrumental manipulation. Surgery should be used at the outset in other instances, and when manipulative efforts fail or complications arise in their wake.

MANIPULATIVE CONSIDERATIONS

With the advent of the operating cystoscope came the début of many original and ingenious devices for removal or manipulation of ureteral calculi. Inventive possibilities of this sort seemed almost limitless. Enthusiasm waxed high at the outset. Mechanical wizards were fascinated, tinkers overwhelmed and the crystal-gazing and wishful-thinking contingent of our profession enthralled. Strange were the developments, grotesque in form, often bungling in application, and many by nature positively dangerous. Some of the safer and better-known devices have withstood the test of time and are still used by certain urologists. Forceps, with serrated jaws mounted on a semiflexible shaft, to grasp the calculus blindly but so constructed as to exclude the mucosa (like the Bransford Lewis instrument), are employed by some for removal of small stones. Basket arrangements to enmesh the calculus, such as the Johnson or Councill extractors, have become very popular. The Howard spiral or corkscrew dislodger, so built as to engage the stone in rotary maneuver, appeals strongly to many urologists.

It is a clinical observation, in fact almost axiomatic, that the nearer the stone approaches the bladder the more susceptible it becomes to manipulation. Moreover, about 75 per cent of all ureteral calculi reach the prevesical spindle. At times a tight ureteral orifice must be enlarged to admit of instrumentation, and to facilitate passage of the stone. This should always be done with the scissors or cold knife through the operating cystoscope. The swelling and reaction engendered by fulguration may add insult to injury, so that as a postlude complete blockage of the side intervenes and catheterization becomes impossible.

It has been aptly said that "An obstinate man does not hold opinions; they hold him." Without wishing to appear obstinate or magisterial, the author desires to protest against all unnecessary intra-ureteral manipulations. None is without danger. Twenty years of experience has made him somewhat gun-shy and ultraconservative in this respect. Even the slight trauma incident to ureteral catheterization may invite infection in the presence of urinary stasis, with renal involvement and septicemia in the offing, not to mention the ever-present danger of perforation of a weakened ureteral wall.

Although the ureter is a fragile structure, Wesson has illustrated with autopsy material that the normal ureter cannot be punctured by the ordinary catheter regardless of the amount of force exerted. On the other hand, a ureteral wall, weakened by the presence of a stone through maceration, inflammatory reaction or pressure necrosis, is a ready object for perforation, and hence the least traumatizing instrument and the most delicate manipulation are required to avoid such an eventuality. In three proven instances (operative exposure), the author has unfortunately poked a stiff catheter through the ureteral wall when it had been weakened by the presence of a calculus. No filiforms or whalebone tips were used in these cases, and no undue force was applied. Such an accident quite easily occurs in the abnormal ureter in spite of the utmost gentleness, all protestations to the contrary notwithstanding, and especially with the new stiff American catheter. Moreover, this liability is directly increased by any therapy to obviate pain or to produce extreme ureteral relaxation such as spinal anesthesia. The author uses the basket type of extractor infrequently and eschews entirely the metal forceps, all metal-tipped appliances and the spiral device—despite the fact that thousands of the latter have been manufactured and sold.

Difference of opinion, however, makes a horse race, and if one must use stone extractors the rule set forth by Bumpus seems excellent, to wit: that no type of extractor should be used which cannot be easily removed after it has engaged the stone. Spiral dislodgers may be reversed. Occasionally the basket type of instrument must be unscrewed and left in situ for 24 to 48 hours, before removal is possible with the stone entrapped. The loop method, as endorsed by Finney, is useful in some hands. The distensible bag has advocates. Physiologic dilatation of the ureter, by simple plugging of the latter temporarily with a sizeable bougie or catheter, is espoused by others. Each urologist has his own pet method for attack, and many of them are highly unique and individualized. Apodictically, greater manipula-

tive leeway is permissible in the prevesical segment than elsewhere. Preference should be based upon simplicity, the incorporated features for safety and the degree of efficiency forthwith.

The author has no talismanic incantation, no magic formula, no cryptic shift, no sleight of hand stratagem nor infallible method to offer for dislodging or facilitating the passage of a calculus. For general use, an indwelling catheter seems most expedient and efficacious. If the calculus is small (and fortunately most of them are), usually a soft ureteral catheter can be adroitly slipped beyond the stone without difficulty. This is fixed in place for 24 to 48 hours and the usual aseptic precautions taken. If the stone is relatively large, 5 c.c. of deproteinated pancreatic extract (Depropanex — Sharp and Dohme) are administered just prior to instrumentation, to facilitate ureteral relaxation. This extract is very potent, so much so that in many instances the stone has been observed roentgenologically to shift its position or even ascend before instrumentation is undertaken. The use of an indwelling catheter drains the kidney (therefore relieves the pain and colic), softens the parts generally and seems to prepare the whole tract for subsequent passage of the stone. Moreover, the catheter's impact often shifts the long axis of the stone into better alignment so as to capitalize advantageously upon the peristaltic efforts of the ureter. At the time the catheter is withdrawn, 3 to 5 c.c. of sterile olive oil are injected. Unless counterindications exist, prostigmin methylsulfate (1:2000 solution in ampules—Hoffman La Roche) is then administered, 1 c.c. hypodermically, every two hours for six doses as a vagotonic agent. The patient is allowed to be up and about during this course of therapy. A rest period is then given the patient, conditioned upon his symptoms, both subjective and objective, and upon the stone's behavior, and if necessary this whole régime is repeated. In other instances the multiple catheter method has served well, but your speaker has not been fortunate in ensnaring the stone by this means. Success often crowns such simple methods, and the stone passes spontaneously within a few days—particularly if the patient can be physically active in the interim. The basket contrivance is kept in reserve for the more difficult case, or one in which progress is not readily manifest.

SURGICAL CONSIDERATIONS

Anent stone management, if ever justifiable criticism is due the profession it is because the surgeon sometimes delays operation too long, hoping for results by the so-called conservative method. In certain instances the latter may become much more formidable or radical than the open attack. Awkward or bungling efforts at manipulation may cause incalculable harm. As an aftermath come chills, fever, pain in the loin, pyonephrosis, an acute surgical kidney or septicemia. Death is cheated only by prompt surgical relief. It must be confessed, however, that the sulfa group of drugs has presently mitigated somewhat the terrors of infection, although their known secondary effects make cautious administration the watchword.

Nice surgical judgment pays handsome dividends in the management of ureteral calculi. Special circumstances often necessitate surgery. Conspicuous therein are the size of the stone (in general, larger than 1 cm. in the upper ureter or 2 cm. in the lower portion), the condition of the corresponding kidney (infection, complete blockage, pyonephrosis, etc.), or that of the opposite kidney (hydronephrosis or congenital anomalies), the presence of several stones (unilateral) or bilateral stones, sepsis and impending uremia, to mention only a few. A sizeable stone above which the ureter is dilated, and which shows no evidence of motility after several manipulative attempts, should be subjected to ureterolithotomy without further ado—especially if the kidney demonstrates any degree of infection or damage.

Aside from other considerations, ultimate choice of technical attack depends somewhat upon the operator's make-up and persuasion. If he is convinced that perseverance and audacity generally triumph, manipulative repetition is almost inevitable. On the other hand, after reasonable effort to facilitate transit of the stone, most men who are surgically-minded prefer, like John Deaver, "to walk by sight rather than by faith." if no progress is forthcoming. The author belongs to this school of thought. He instinctively hates to wrestle in the dark with an unknown adversary, for like Jacob of old he may prevail not. Somehow it seems a bit rash to grapple blindly for the stone with serrated jaws of steel in such narrow confines, despite elaborate safeguards to exclude the mucosa. Should success reward such daring, and perchance the stone be cleanly captured, it would tax even Houdini's skill to pull forth a small calculus in this manner without stripping or traumatizing the ureteral mucosa irreparably. A large stone cannot be extracted in this way and the ureter may be divulsed in the attempt. Again it seems both imprudent and hazardous to rotate a spiral bludgeon of steel, a veritable "go-devil," up such a thin and defenseless little tube. Nor does it appear much less perilous to open a bear-trap (even though flexible) in the same fragile tube for purposes of ensnaring the calculus. Finally, it requires a world of fortitude and optimism in the face of discouragement, and in absence of progress, to continue feeble titillation of the stone with a pliable ramrod. Hence the sophisticate is prone to thrum the surgical string to his bow.

Ureterolithotomy becomes, therfeore, something of an "Open Sesame" for the patient and surgeon alike in many instances, and is always a sheet anchor. Moreover, the operation is quickly and easily done. The mortality is very low save in the superannuated (especially because of em-

bolic possibilities in pelvic surgery), and the convalescence is usually rapid and uneventful. Conversely, it must be admitted that no surgery is devoid of danger, and that occasionally disagreeable sequelae arise (particularly in the prevesical segment) such as urinary fistula, postoperative stricture or even complete ureteral occlusion.

It should be a urologic maxim, always to recheck the position of a stone just before the patient is taken to surgery, or after he has been placed on the table. Pursuant to the freakish behavior pattern, any stone may shift about or alter its position abruptly and entirely without the production of symptoms, be the interval since the last roentgenogram ever so brief. To be thus forewarned leaves nothing to chance. In the event of bilateral calculi, it seems the part of discretion to operate one side at a time, save in rare and unusual instances. As a general rule, the less involved side is subjected to the initial attack. Surgically considered, the territory in and about the uretero-pelvic juncture and the prevesical spindle are of particular interest since stones rarely become lodged or impacted in the middle third of the ureter.

For stones lodged in and about the ureteropelvic juncture the author prefers a modified Mayo incision, similar to that used for kidney exposure, but possibly placed a little lower than the latter. Efficient work depends upon good exposure. Great care is taken in handling the ureter; a clean-cut incision is made into the ureteral lumen in the long axis of the tube, and the stone removed with specially designed forceps. This incision is commonly begun over the stone and carried upward. Rough handling or tearing of the ureter in the process of removing the stone is to be avoided. No sutures are used in the ureteral wall, unless the tube is greatly dilated or the incision therein overly long. The advantage of ureteral sutures is still a moot question. Drains, of course, are necessary.

Stones impacted in the prevesical spindle give the surgeon the most concern. The great depth at which they lie in the pelvis, and the tendency to persistent venous oozing make good exposure difficult. Moreover, in the male the anatomic juxtaposition of the seminal vesicle but worsens the situation. The author prefers to pass a ureteral catheter beyond the stone at the outset, if possible. This catheter acts as a guide, prevents rolling of the ureter and tends to immobilize the stone while the incision into the ureteral wall is being made. A midline or suprapubic approach is easiest and gives the best exposure, and may be prolonged upward if the stone is lodged higher. The empty bladder is crowded to the opposite side of the pelvis and the stone located. Directly an Allis clamp is applied loosely to encompass the ureter and periureteric tissues en masse above the stone, in order to prevent the latter from slipping upward in the dilated tube. Blunt dissection and painstaking effort are required to gain depth. Time spent to care for venous oozing is profitable. The stone is delivered with forceps through a clean-cut incision. Undue traction and awkward efforts in delivery are interdicted. Patency of the ureter above and below the incision is established. No ureteral sutures are needed for coaptation. Drains are always necessary.

Sequelae comprise prolonged urinary drainage which is often indicative of an obstruction between the bladder and ureteral incision, such as a stone spicule. Postoperative strictures are not uncommon, and must be cared for by ureteral dilatations. Good drainage insures against infection. Postoperative occlusion of the ureter is not rare, and sometimes passes unnoticed because of the absence of symptoms. In a series of 42 ureterolithotomies (prevesical spindle) the author has had this misfortune occur 5 times. Nephrectomy was necessary in 2 instances. Another fairly common sequela, not mentioned in textbooks, is the postoperative development of epididymitis on the affected side. Moreover, the latter is apt to be very troublesome and recurrent in the author's experience.

A comprehensive subject, like the management of ureteral calculus, is necessarily an arbitrary one, and its very mention causes many avenues for discussion and different interpretation to unfold. Three interpretations or ideologies are quickly apparent, to wit: your own opinion, the other fellow's and the correct one. While these erstwhile opinions are certainly tendered in no spirit of *magister dixit*, nor yet in a vainglorious style, the author feels inclined to make no apologies for them. These opinions, which emanate from the Sacramento quarry, represent: sincere convictions based upon twenty odd years of clinical experience; much thought and study, trial and error calibration at the bedside; tachycardia induced by the spiral or "go-devil" dislodger; labor with ingenious bear-traps for stone removal; sweat at the operating table; travail in pitfalls; tears and curses for bungling mishaps; gratitude for Nature's benevolent help; faith, hope, and charity for the newest panacea in the matter of prevention; and a ceaseless struggle for enlightenment and truth with regard to the management of ureteral stones. Nevertheless, it must be admitted that these opinions are only the author's and may neither concur with the other fellow's nor be the correct ones.

EPITOME

1. Calculus is common in the Sacramento Valley, ureteral stone causing the majority of upper urinary tract involvement in this geographical area.

2. Study of the stone is a prerequisite to proper management: i.e., size, shape, number, anatomic emplacement and motility. Study of the patient is also obligatory: i.e., general, local and associated conditions.

3. Watchful waiting is not always amiss, since spontaneous expulsion is not infrequent. Error in

judgment, or leaning too far toward conservatism, however, may result in greatly increased morbidity and perhaps otherwise avoidable mortality.

4. Author's expectant treatment consists of insertion of a soft indwelling ureteral catheter left in situ for 24 to 48 hours, under aseptic conditions. Sterile olive oil is injected upon withdrawal of the catheter, and prostigmin methylsulfate is given hypodermically with the patient ambulant. For large stones, deproteinated pancreatic extract administered just before instrumentation aids in securing ureteral relaxation. Metal forceps and metal-tipped stone dislodgers have no place in instrumentation within a ureter weakened by stone, as demonstrated by three known personal cases wherein perforation occurred.

5. Failure to respond to a reasonable trial of manipulative measures should be followed by immediate open operation. Unnecessary intraureteral manipulations should definitely be excluded on a physiologic basis.

6. About 75 per cent of ureteral stones reach the prevesical spindle. If ureteral meatotomy is necessary, scissors or cold knife are preferable to fulguration, for the occlusive effects of the latter may defeat its purpose.

7. Warning is sounded to recheck position of stone immediately before surgery.

8. Author's technique of ureterolithotomy is given, stressing the importance of adequate drainage.

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CHRONIC BRUCELLOSIS: DIAGNOSTIC POINTS NOTED IN ONE HUNDRED CASES

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A NEW doctor's dilemma appeared when Harris[1] published his monograph, "Brucellosis," in April, 1941. The acceptance of this work has met with considerable resistance on the part of some experts in the field of infectious diseases, because it makes chronic brucellosis appear to be a far more common disease than was ever supposed, and it throws a tremor into practically all our previous standards of laboratory diagnosis of active brucella infection.

Dr. Harris maintains that chronic brucellosis can and does simulate practically every other disease in its varied symptomatology. He shows that fever is not always present,* and that the agglutination test is usually negative in chronic cases of active infection. To culture the brucella organisms from the blood or other body fluids of a chronically-infected case is very difficult, expensive, and usually unsuccessful; yet the disease has been proved by positive cultures when all other laboratory and skin tests were negative. The opsonocytophagic power of the patient's blood may be low, moderate, or high. The leucocyte count may be low, normal, or high. There may or may not be anemia. The color index may be high, normal, or low. The differential count may be normal, or show lymphocytosis or granulocytosis. The intradermal test is most likely to be positive, but it may be negative or questionable. If positive it means only that the body has acquired a sensitivity to the Brucella proteins, presumably from past contact with the germs. Like the tuberculin test it does not in itself distinguish between an active infection and a healed, past infection. Furthermore, a positive skin test, if given before the blood tests are made, may alter the latter and thus make subsequent blood tests indeterminant because of possible false positive reactions. The same criticism might be made of the therapeutic test with vaccine, which cannot, anyway, be interpreted accurately in a short time. Unlike syphilis, which also can mimic any disease, brucellosis has no test comparable to the Wassermann reaction in reliability and applicability.

Thus we are confronted with the concept of a specific infectious disease whose symptoms and immunologic features are more protean and inconstant than have ever been known before. Such a concept should naturally be resisted by well-schooled and conservative minds.

The present study is concerned with an analysis of the diagnostic data in 100 cases of chronic brucellosis. These cases have been seen and studied in the course of a general private practice. Whether they are true cases of chronic brucellosis, is, in the present state of diagnostic criteria, subject to individual interpretation. They are accepted as true diagnosis by the author because of certain combinations of findings in each case, and because of the clinical course both before and after specific vaccine therapy. Twenty-five additional cases of probable brucellosis were omitted from this study because of incomplete or inconclusive data, or the presence of other concurrent disease.

THE FACT OF ILLNESS

Regardless of test results, the diagnosis is not made unless the patient is suffering from real illness. All of these patients were sick enough to seek medical care voluntarily on a private-fee basis, because of disability and/or discomfort of a persistent or recurrent nature. Routine laboratory tests done on healthy cattle-handlers and slaughter-house workers will show some positive results, but such healthy persons do not have the disease within the meaning of this study.

DURATION OF ILLNESS

When the chronic disease has an insidious onset, the duration is difficult to ascertain with certainty. The diagnosis was not made unless the

* The term brucellosis is preferred to "undulant fever," "Malta fever," etc., for this reason, among others.

symptoms had persisted at least 3 to 6 months. Only 11 cases had a duration of one year or less. The largest number had been seeking relief for 5 to 10 years. The distribution is as follows:

3 mos. to 1 year	11 cases
1 year to 3 years	24 cases
3 years to 5 years	18 cases*
5 years to 10 years	28 cases**
10 years to 20 years	11 cases***
20 years to 30 years	5 cases
10 years to 50 years	1 case
36 years	1 case
57 years	1 case
Total	100 cases

* Includes "Few years" and "1 to 6 or 8 years."
** Includes "Years."
*** Includes "Many years."

The cases of longest duration are often the most difficult to "cure," but the patients are most appreciative of the results of vaccine therapy. The therapeutic results in the seven longest cases have been rated as 1 "excellent," 2 "very good," 3 "good," and 1 "fair."

TYPE OF COURSE

The undulant course is conceived as that in which there is always a condition of ailing, or lack of vigorous health, with constant "ups and downs," so that the patient never feels perfectly well, is frequently miserable, and occasionally obviously ill, clinically. The remittent course is that in which complete remissions of apparently normal health are interspersed between recurrent periods of quite consistent symptomatology. Both types of course are typical of chronic brucellosis and there are gradations between them. Two cases are classified as "constant" because, for more than 10 years before treatment, both patients were always too uncomfortable to appreciate relativity to any great extent.

In this series the course of the disease before diagnosis was as follows:

Undulant Course	76 cases
Remittent Course	22 cases
Constant Course	2 cases
Total	100 cases

HISTORY

A long and searching history is the first step in diagnosis. It includes a careful tabulation of symptoms, as well as past illnesses and diagnoses. The duration and reappearance of each symptom are considered important. A history can be considered characteristic if it presents a long period of mild ill-health, with frequent more intense attacks in which the diagnoses are varied, atypical, or frankly puzzling. A history of persistent or recurrent low-grade fever is most significant. "Flu" every year, or several times a year, is a frequent story. Many times a diagnosis of neurosis or constitutional frailty has been made. Another suggestive point is the failure to improve or recover in spite of good treatment for the supposed diagnosis. Instability of visual acuity and stubborn "allergies" are not uncommon clues.

The symptoms presented by these cases will be analyzed more fully in another report. The most common complaints can be listed as follows:

1. Ease of fatigue, lack of energy, weakness, or lethargy, appearing both chronically and in attacks. This symptom, in one form or another, is prominent in practically every case of chronic brucellosis. The diagnosis should be looked upon with suspicion if this symptom is not easily elicited. This is not true of any other symptom.
2. Aching or pain in the muscles, nerves, joints, or bones.
3. Headaches, and often light-headedness, in attacks.
4. Catarrh, postnasal drip, "sinusitis" or "allergy."
5. Digestive system disorders, usually with excess gas, and called by many diagnostic terms.
6. Fever. Many patients are unaware of one degree of fever: others feel it at 99°.
7. Less common symptoms are tachycardia, palpitation, excess perspiration, epistaxis, and a host of others.

The patient usually does not know where to begin giving his history. He has two or three or more chief complaints, and if he starts to name off all his symptoms he sounds like a neurotic for the following reasons:

1. His symptoms are varied.
2. They are apparently unrelated.
3. They are often inconsistent individually.
4. They are minor symptoms for the most part, in that they are usually not quite typical of any major pathology.
5. They are of long duration, but they disappear now and again for no apparent good reason.
6. They do not respond to symptomatic treatment very well, nor to psychotherapy; or, if they do, the cure is not permanent.
7. The patient has been "doctoring" for a long time, has had many plausible diagnoses and treatments, has usually been told that he is neurotic, and by this time he often is, to some extent.

SOURCE

The use of raw milk, at least occasionally, is so widespread that a history of it may mean little or nothing in the diagnosis. On the other hand, in California it may mean a great deal, because there is no State law providing for control of Brucella infection in cattle (Bang's Disease or Contagious Abortion). Only in the certified herds is there any regulation that might warrant confidence. A history of customary consumption of raw milk daily or occasionally is considered worth asking about in diagnostic studies. The absence of it, except in cattle-handlers or laboratory technicians, throws doubt on the diagnosis, but it cannot alone rule it out. In several cases in our series this point of history was not asked for. We know of no positive case in which the patient has absolutely rigidly avoided raw milk in every form. The analysis follows:

Definite history of raw milk consumption	71 cases
Cattle handler, usually drinks pasteurized milk	1 case
Cattle handler, drinks raw milk	1 case
History of raw milk not elicited	27 cases
Total	100 cases

FEVER

Fever, if present or recurrent in the history, is an important diagnostic indication, because it is an objective sign as well as a symptom. A single short bout of fever, even if unexplained, cannot be considered suggestive of chronic brucellosis. It is now well known that chronic brucellosis can be present, even actively, without fever. The determination of the fever record is done with a thermometer certified to require no correction at any point on the scale. It is left under the tongue for fully five minutes at various times of day, until the time of maximum temperature is discovered. The temperature at this time of day is recorded for a week or more. Slight allowances are made for excessively hot weather, and the menstrual onset in women. Longer records eliminate these factors of possible error.

The occurrence of fever before treatment in this series was as follows:

Fever present in	74 cases
Fever absent in	23 cases
Fever not determined in	3 cases
Total	100 cases

* * *

Usual maximum near-daily fever of 99° or less in	13 cases
Usual maximum near-daily fever of 99° to 100° inclusive in	39 cases
Usual maximum near-daily fever of above 100° in	6 cases
Unspecified or "occasional" or "frequent" in	16 cases
Total	74 cases

In scarcely any case was the fever the most important deciding factor in the diagnosis. It is chiefly an evidence of the organic nature of the patient's condition, and an indication of some infection. In conjunction with the history and the blood count it may form an important link in the chain of data. In this series every case which had a normal temperature was amply buttressed with a combination of other competent diagnostic findings.

PHYSICAL EXAMINATION

No physical findings are considered indicative of chronic brucellosis. In fact, an important diagnostic point is the absence of physical findings capable of explaining the symptoms. Fever is the most important discovery, and it is surprising how often it is omitted from office examinations. In hospitals the temperature is often taken too hastily to be reliable. An enlarged liver or spleen should make one think of the possibility of brucellosis. In this series the liver was enlarged in two cases, the spleen in another, and two presented a possible enlargement of the spleen by percussion. The most frequent finding in this series was a peculiar pallor which has been described by others. It was noted in 35 cases. When it is present the facial skin has the appearance of very old, faded, limp leather. The muscles in the skin are relaxed and atonic. The face looks tired and simply colorless. There may be redness about the nostrils and base of the nose. The next most common finding was redness of the mucous membranes, especially of the nose. The anterior end of the septum often presents small white crustings, as if sprinkled with a few grains of salt on a reddened background. Increased redness of mucous membranes was noted in 20 cases. It was interesting that most of the patients in this series complaining of "allergy" failed to show pale mucous membranes and eosinophilia in the blood. Five cases presented by x-ray and/or physical examination destructive Brucella bone lesions.

BLOOD PICTURE

Calder, Steen and Baker[2] described the blood structure in nearly 300 cases of brucellosis, and pointed out that, while it is not diagnostic in itself and not always present, there is a typical combination of blood count data not duplicated as uniformly in any other clinical entity. Their typical picture included the following: (a) relative lymphocytosis, often absolute and active; (b) leucopenia in 1/4 of the cases, a normal leucocyte count in 1/2, and a leucocytosis in 1/6 of the cases; and (c) a mild macrocytic hyperchromic anemia. They also found a moderate eosinophilia in 1/5 of the cases, a normal monocyte count, and a few other minor points not checked in the present analysis.

In the present series the initial blood studies were done before the patient was given any skin test or vaccine. The lymphocyte count was:

Not done in	3 cases	
Below 30% in	15 cases	
30 to 34% incl. in	23 cases	
35 to 40% incl. in	19 cases	
41 to 50% incl. in	26 cases	
51 to 60% incl. in	12 cases	60%
62% in	1 case	
82% in	1 case	
Total	100 cases	

The total leucocyte count was:

Below 6,000 in	43 cases	(44.8%)
6,000 to 10,000 in	46 cases	(48.0%)
Above 10,000 in	7 cases	(7.2%)
Not done in	4 cases	
Total	100 cases	

The hemoglobin was below 14 Gm. in 63 cases (67%).

The hemoglobin was below 12 Gm. in 12 cases, the lowest being 9.5 Gm. in a case with a positive blood culture.

The color index was derived by the method of Isaacs[3] in which $\frac{\text{Hbg in Gms.} \times 3}{\text{RBC in millions (1st two figures)}}$ equals the index. This gives a slightly lower figure than some other methods in use, but it seems to be more accurate than those based on per cent of normal hemoglobin. The color index was:

Below 0.9 in	11 cases
1.0 or above in	41 cases (44%)
0.9 to 1.2 in	81 cases (87%)

The monocyte count varied from 0 to 9 per cent, the average being about 3 per cent.

The eosinophile count was usually normal. The maximum was about 4 per cent, and it occurred in only 4 cases out of 97 counts.

The blood sedimentation rate was very variable. It is not a particularly helpful test, except that its frequently normal rate in brucellosis helps to differentiate it sometimes from active tuberculosis, rheumatic fever, and other conditions which usually show a rapid sedimentation rate. It was:

Normal or prolonged in 28 cases (two-thirds of those tested).

Rapid in 10 cases.

Slightly accelerated in 2 cases.

The blood picture was helpful in diagnosis, by virtue of the work of Calder, and others, in 47 cases in this series of 100. It is not often a decisive factor of much moment in itself. It can be interpreted accurately only in the light of other evidence. Leucopenia, for example, should be judged partially in relation to fever.

URINE EXAMINATION

This has usually been done so many times in so many places with negative results for most of these patients, that it is usually omitted unless the history indicates it. A small amount of albumen or a small amount of pus has not uncommonly been a misleading finding in the diagnosis of a patient with chronic brucellosis. When due to brucellosis these small urinary findings usually clear up in a short time spontaneously. Meanwhile the symptoms referable to the urinary system may be all out of proportion to the findings.

BLOOD CULTURE

The blood culture[4] for Brucella was negative in 5 cases and positive in 1 case. In the case with the positive blood culture all other laboratory and skin tests were negative, weak or questionable. Cultures have been seldom done in chronic cases unless the fever is above 101° or there is a focus of infection. Culturing for brucella is a difficult, expensive and usually disappointing procedure, especially in private practice.

AGGLUTINATION TEST

It is now well known that the agglutination test is more often negative than positive in the chronic form of brucella infection.[1, 7, 5, 6] The blood was always taken for the initial agglutination test before the patient was given vaccine or any skin tests. The initial agglutination tests for diagnosis resulted as follows:

Negative in 86 cases (89 per cent). One of these was reported positive by another laboratory, but the specimen was partly hemolyzed.

Positive in 10 cases, two of which were questionable because of partial hemolysis of the specimen, and a third one was also reported negative by another laboratory.

Positive in a titer of 1:80 or higher in only 4 cases, two of which were questionable because of partial hemolysis.

Positive in a titer of 1:40 in 3 cases, one of which was also reported negative by another laboratory.

Positive in a titer of 1:20 in 1 case.

Positive in unspecified titer in 2 cases.

Not done in 4 cases.

The agglutination test was the least useful of all tests, except in the 7 cases in which it was unquestionably positive.

After treatment with vaccine was begun, the negative agglutination test became positive in at least 29 cases, 5 of them in titers of 1:320 or higher, and 17 in titers of 1:80 or higher. The positive agglutination test became negative after beginning treatment in three cases, in all of which the patients were hypersensitive to Brucella proteins to the point of skin necrosis. Treatment has not yet changed the agglutination test in 31 cases, whether positive or negative. Retesting has not been done in 33 cases.

COMPLEMENT FIXATION TEST

In the present series this test has been too little used to permit an appraisal of its value.

OPSONOCYTOPHAGIC INDEX

The blood is always taken for this test before any vaccine or skin test is given. The power of the polymorphonuclear leucocytes to phagocytose living Brucella bacteria from a fresh culture is tested by Falk's modification[1] of Huddleson's method[8] using carefully citrated blood less than 6 hours old. The stain used is usually a modified Wright's rather than Hastings'. The slides are read by the method of Huddleson, and recorded also in terms of the phagocytic index number of Foshay and LeBlanc.[9] The latter is used in this report because it expresses the phagocytic power simply in per cent of the total maximum potential capacity of blood for brucella phagocytosis. Some consider the test "negative" when the phagocytic index number is below 10, others 20. The report from the laboratory should also show the distribution of the cells as they vary in phagocytic power. If some leucocytes ingest as many as 21 to 40 bacteria, and no cells fail to ingest bacteria, the test approaches diagnostic capacity. The significance of the test can be judged only in conjunction with other findings. The distribution of our cases as to phagocytic power is as follows: (See also Fig. 1.)

The average index number was about 20. Of the 11 cases not tested at first, 9 had phagocytic

index numbers of 78 to 97, after beginning vaccine treatment. Of 64 patients who have been given the opsonic test after beginning vaccine treatment 46 (or 72 per cent) have phagocytic index numbers of 61 to 99. Exactly half of these had index numbers of less than 20 before receiving vaccine. In 4 cases with initial high phagocytic power (No.'s 45, 65, 70, and 90) the first effect of vaccine was to lower the phagocytic numbers (to No.'s 23, 19, 58, and 20).

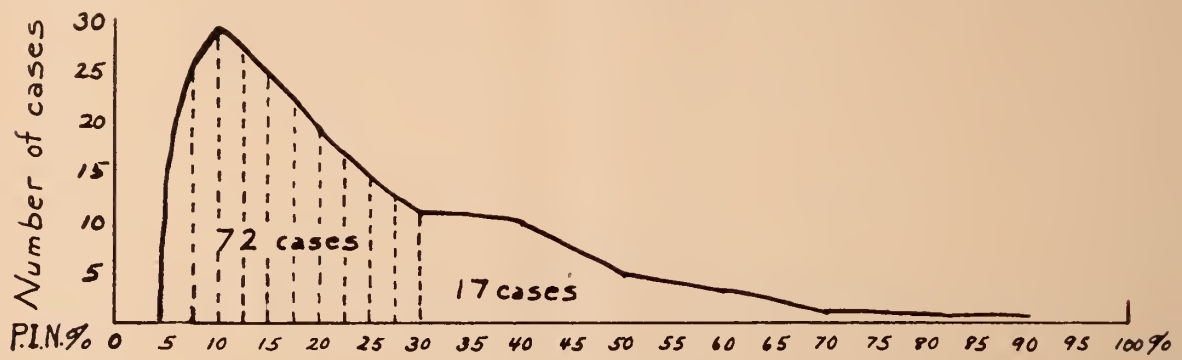


Fig. 1.—Phagocytic Index Number (Foshay) Before Treatment and Before Skin Test.

Phagocytic Index No. 10 or lower in	42 cases
Phagocytic Index No. 11 to 30 inclusive in	30 cases
Phagocytic Index No. 31 to 50 inclusive in	14 cases
Phagocytic Index No. 51 to 90 inclusive in	3 cases
Not tested before skin test in	11 cases
Total	100 cases

The initial opsonophagocytic test was helpful in the diagnosis of 31 cases, and its rapid rise to a high level after beginning vaccine therapy was considered of some diagnostic significance in 32 additional cases. It cannot make the diagnosis by itself, but properly interpreted in the light of all other evidence, it may add weight. It will not serve by itself to rule out the disease. Like the agglutination test, it is not a test of infection, but an index of one kind of resistance. It is subject to much error from human factor, time factors and the variation in methods. The test can be made valuable in diagnosis when these three factors are properly standardized.

INTRADERMAL TEST

This most useful test is very easily abused. In the first place, it should not be given until blood tests and fever record are completed. Second, vaccine should not be used for the initial skin test. Third, Brucellergen 1:12,000 (Huddleson) is milder than vaccine and may be used, but it should be diluted with 9 parts of sterile physiological saline for the initial test. This gives a dilution of 1:120,000. Fourth, a control test using the diluent saline should be given at the same time. Fifth, the tests should be read by the doctor or his trained assistant at both 24 and 48 hours. If the test is completely negative another skin test may be given after 48 hours, using Brucellergen 1:12,000 or 1:48,000, if the first test was questionable. Only if the Brucellergen tests are completely negative and the disease strongly suspected for other reasons should the vaccine be used intradermally; then diluted 1:4 or 1:100. If other tests *prove* the existence of the disease in active form, the skin test should be omitted.

The reason for this caution is that necroses and near-necroses of the skin are easily caused by strong concentrations of Brucella protein in sensitized persons with the disease (about 21 per cent in our series). Of course these lesions will heal, but they increase the patient's sensitivity to the point of making vaccine therapy extremely difficult, if not impossible. Furthermore, the patient's symptoms are aggravated by his increased sensitivity. This can be avoided by using sufficiently weak dilutions until the patient's tolerance is clearly adequate. The significance of the skin test is the same as that of the tuberculin test. Other data are necessary to determine whether there is an active infection at the time of testing. A negative skin test does not rule out the disease in the face of other strong evidence, but it makes the diagnosis very unlikely. We believe that if various strengths of protein are used every infected case will react locally or generally to some dilution. Positive tests are usually, but not always, indurated, and raised above the level of the skin surface. They are best compared with the control. A test may be positive if it is flat, but persists for many days or weeks; or, if it presents a petechial ecchymosis in the tested area not due to striking a skin vessel with the needle.

Our results with the intradermal tests were as follows:

Positive in	97 cases
Negative or questionable in	2 cases
Not done (unnecessary) in	1 case
Total	100 cases

The positive tests are further analyzed as follows:

Four plus with necrosis of the skin:

From Brucellergen 1:120,000 dilution in	0 cases
Brucellergen 1:48,000 in	1 case
Brucellergen 1:12,000 in	7 cases
Vaccine in	3 cases
Total Necroses	11 cases

Necroses occurred in 10 per cent of cases tested with vaccine.

Prolonged 4 plus with near-necrosis (premature dry desquamation of epidermis):

From Brucellergen 1:120,000 dilution in	3 cases
From Brucellergen 1:48,000 dilution in	2 cases
From Brucellergen 1:12,000 dilution in	4 cases
Total Near-Necroses	9 cases

Total necroses and near-necroses—20 cases.

* * *

Cases tested with Brucellergen 1:120,000 dilution
Positive in.....19 cases (83%)
Questionable or Negative in..... 4 cases (17%)

Cases tested with Brucellergen 1:48,000 dilution
Positive in.....23 cases (92%)
Questionable or Negative in..... 2 cases (8%)

Cases tested with Brucellergen 1:12,000 dilution
Positive in.....43 cases (77%)
Questionable or Negative in....13 cases (23%)

Positive to Brucellergen in some dilution in 80 cases (84.3%).

Questionable or Negative to Brucellergen in any and all dilutions in 15 cases (15.7%).

Brucellergen test was not done in 5 cases.

Positive to commercial vaccine intradermally in 26 cases (93%).

Vaccine skin test was not done in 70 cases.

Positive to vaccine and Negative or Questionable to Brucellergen in 14 cases.

Positive to *undiluted* vaccine and Negative or Questionable to all others in 5 cases.

Negative or Questionable to *undiluted* vaccine and to all others in 2 cases (2%).

Properly used and interpreted in the light of all other data, the battery of skin tests is the most valuable of the objective tests in the diagnosis of chronic brucellosis. Abuse is the only thing that should discredit it. In our series the skin tests were negative or questionable in only 2 cases: one, a subacute case proved by blood culture; the other, a woman who had had the disease, undiagnosed, for 36 years. She had a chronic undulant dermatitis. Her response to vaccine therapy was "good, far better than any other treatment had ever been." Her diagnosis was based on history, palpable liver, enlarged spleen to percussion, the exclusion of other diseases, and her response to Brucella vaccine therapy alone.

EXCLUSION OF OTHER DISEASES

This is a most important step in the diagnosis. Brucellosis is very easily confused with many diseases which are potentially dangerous and should never be overlooked, while chronic brucellosis is a relatively benign condition. In our series most of the patients had been studied for a long time by a number of competent physicians and reputable diagnostic clinics. Most of the exclusion of other diseases had already been done. However, Wassermann tests, tuberculin tests and/or x-ray studies are practically routinely done. Sinusitis, eyestrain, migraine, amebiasis, allergy, cholecystitis, peptic ulcer, arthritis, hypo- and hyperthyroidism, hypoglycemia and neurosis must frequently be eliminated or assigned their proper places in the patient's total condition. The present study omits any patient who has a coincident disease which might be capable of explaining the total morbidity in the case. Systematic exclusion of other probable diseases was considered necessary and played an important part in the diagnoses of 59 cases in the present series. Most of the others had medical histories which either excluded other probable diseases or included unsuccessful treatment for them.

RESPONSE TO VACCINE THERAPY

The "final proof" would be easier to judge if vaccine therapy were easy. It is difficult. However, the patient's response and reaction to specific therapy, even though short of complete cure, is not difficult to see. With the exception of 9 relatively new cases and 7 whose improvement is rated as "Fair," all the patients in this series have either responded to vaccine with impressive improvement, or have reacted with severe hypersensitivity leaving no doubt of their diagnosis. The purpose of this study is to present the diagnostic features of 100 unquestioned cases of chronic brucellosis; therefore cases which have failed a therapeutic test are omitted.

The response and reaction to vaccine therapy includes the effect of the intradermal test whenever this effect is very pronounced locally or generally. The figures are as follows:

Improved	83 cases
Unimproved (all hypersensitive)	8 cases
New cases, relatively untreated	9 cases
Total	100 cases

* * *

Hypersensitive cases improved	16 cases
Hypersensitive cases unimproved	8 cases
Total hypersensitive	24 cases

Improvement in hypersensitive cases is usually, though not always, the result of desensitization with ultra-minute doses of oxidized Brucella abortus and suis vaccine.[10] Most of the unimproved cases are being prepared for desensitization.

In the further analysis of the improved cases, unsatisfactory terms must be used for lack of others.

"Poor" means that the treatment was consistently or finally disadvantageous.

"Unimproved" means neither better nor worse finally. During treatment several of these cases were alternately much better and much worse. These hypersensitive patients are the ones in whom ordinary doses of vaccine seem to "bring out the disease" temporarily.

"Fair" means definite subjective or objective improvement, but no complete relief from symptoms for longer periods than the natural course of the disease provides for that individual.

"Good" means "Better in every way" or "better than I have been for years," or "30 to 80 per cent improved."

"Very good" means marked improvement or loss of disability, or relatively long remissions from symptoms. Sometimes it means a spectacular relief without complete return of constant health and strength. From "80 to 200 per cent better."

"Excellent" means apparently recovered for a sufficient number of months, and with sufficient speed to suggest that a permanent remission may be possible.

* * *

New cases	9 cases
Poor results	0 (in this series)
Unimproved (all hypersensitive)	8 cases (8.7% of treated cases)
Fair results in	7 cases (7.6%)
Good results in	37 cases (40%)
One was very good, but the patient quit treatment and relapsed.	
Very good results in	24 cases (27%)
Excellent results in	15 cases (16%)
Total	100 cases

CONCOMITANT THERAPY

One of the "very good" results counted above occurred in a 32-year-old woman with intermittent back pain. The relief may have been due in part to thyroid medication which she had never been given before. In all other cases there was no concomitant therapy which could have been expected to relieve the chronic condition. Patients with anemia are given ferrous sulphate, liver fraction, and Vitamin B_1 by mouth, but they have had plenty of these before without appreciable effect on their total condition. Several patients with digestive symptoms have been given bile salts without cathartic, but they have usually had such preparations before, and any good effect has been limited to the digestive system. Estrogens were continued in two cases; otherwise treatments for other supposed diagnoses were generally discontinued.

DIAGNOSTIC COMBINATIONS

The diagnosis is never made from any one test or from laboratory findings alone, or from clinical findings alone. It is always made from a synthesis of all obtainable evidence in each case. In this series 10 separate diagnostic factors are studied, *viz.:* history, skin test, fever, exclusion of other diseases, blood picture, opsonic test, agglutination test, physical findings including x-ray, blood culture, response and reaction to vaccine therapy. Mathematically these factors can occur in 967 combinations of three or more. For diagnostic significance only a much smaller number of combinations can qualify. In our study we found a total of 37 adequate combinations of the 10 diagnostic factors. Ten combinations accounted for 60 per cent of the diagnoses and were as follows, in the order of their frequency:

1. History, skin test, fever, exclusion, response.
2. History, skin test, fever, exclusion, blood picture, response.
3. History, skin test, blood picture, response.
4. History, skin test, exclusion, blood picture, response.
5. History, skin test, fever, response.
6. History, skin test, fever, exclusion, blood picture, opsonic, response.
7. History, skin test, fever, exclusion, opsonic, response.
8. History, skin test, fever, blood picture, opsonic.
9. History, skin test, fever, blood picture, response.
10. History, skin test, exclusion, response.

In individual cases the strength and significance of the diagnostic factors may differ widely from the order in which they are listed above. "History" includes symptomatology, duration, source, and course.

SUMMARY AND CONCLUSIONS

1. The diagnosis of 100 cases of chronic brucellosis appears to be firmly established by an analysis of all the data. These cases form the basis of this study.

2. The diagnosis is based chiefly upon a searching history, the exclusion of other diseases, positive intradermal tests, properly done, certain combinations of about ten other tests and findings, and the patient's response to Brucella vaccine therapy.

3. The agglutination test is usually the least valuable of tests for chronic brucellosis, but it should not be discarded.

4. The skin test is most valuable and most easily misused. Great care should be taken not to increase the patient's sensitivity to Brucella.

5. The relative importance of the other tests in the diagnostic analysis is estimated. The laboratory offers no test or tests which can substitute for thorough study and keen clinical judgment.

6. The diagnosis is difficult chiefly because of (a) the protean nature of the disease, (b) the inadequacy of laboratory tests for proving or disproving the diagnosis, and (c) the time and expense involved in ruling out many other diseases with which it is easily confused.

7. Chronic brucellosis in man is a very important cause of ill-health, especially in areas where the infection is not controlled in dairy herds. This study appears to support the newer concept[1, 5, 6, 7, 11] of the nature of Brucella infection in man.

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MENTAL ILLNESS: ITS EARLY SIGNS*

RÔLE OF THE FAMILY PHYSICIAN

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THERE is a fundamental difference between psychiatry and all other branches of medicine. A brief historical perspective leaves no doubt but that it was the suffering of the sick that created the primitive medical man, the ancestor of our present day highly-trained physician. Those who were physically sick never doubted their sickness, but loudly demanded help and relief from their pains, and the doctor had to respond and serve. From the earliest days of which we have record we find the doctor an idealized figure who, in turn, was expected to serve his patients with single-minded steadfastness and devotion.

When we turn to mental illness the historical picture changes completely. In the first place, the patient did not recognize himself as sick. A mind that is "lost" cannot surely be expected to take the lead in searching for itself. Moreover, he was often the first to insist that if any discrepancy existed between his ideas and those of the community, it was the latter who were unenlightened and out of step. The phenomena of mental illness were frequently so impressive that the baffled community was forced to concede the presence of supernatural powers, and delegated their religious authority to deal with those who were thus set apart from normal mortals. Thus began the insulation of the manifestations of mental illness from the inquiring but unhallowed touch of the scientist; and when, several milleniums later, the scientist first suggested that mental illness was a result of natural causes, he was met by terrific and passionate resistance to the point of persecution.

So it was that, whereas sickness created doctors, doctors working against the law of the State and the will of established religious faiths, created psychiatrists. This occurred only a few centuries ago, and the conquest of the field of mental disease by medicine is still far from complete. In no other field of disease is there such a preference for quackery in the form of "guidance" by amateurs, lay and clerical, and in no other field is it so necessary to refresh the thinking of the medi- Mark Twain's "damned human race," and he cal profession itself as to the aims and techniques of the group of specialists who are working in it.

In spite of the brief span of years during which mental illness has been considered a pathological entity, we are today faced with the somewhat paradoxical fact that our facilities for the care of these patients are being strained to the utmost. We can reduce this pressure on our mental hospitals by prevention, and by early diagnosis and treatment. As with chronic disease in general, early recognition will not only reduce the duration of treatment, but may obviate the need for hospitalization entirely. What has been said above by way of introduction, shows quite clearly why the burden of this task of early recognition falls, not upon the shoulders of the psychiatrist, whose practice is largely referred, but upon the general practitioner and family doctor. He is the one to whom patients and the families of patients, first bring their problems, and it is he who can take the initiative in bringing to the attention of patient, or family, the existence of mental illness. The family doctor sees his patients in their sickness and trouble over a period of years. He watches the children develop and notes the interplay between parents and children, and between the children and the world in which they live. People go to their doctors, not in order to demonstrate their strength and achievement but, rather, to confide their weakness and their failure. No one has a better chance than the physician to learn what lies behind dissimulation and the social mask. It is this type of relationship and the consequent wide knowledge of human nature which, should he be so inclined, qualifies the family doctor to recognize and deal with the early symptoms of mental illness.

BASIC CRITERIA OF MENTAL HEALTH

The basic criteria of mental health are simple and depend only upon common sense for their evaluation. They are these: Are the objectives for which the person is striving understandable, and in harmony with his personality, and are the means employed to bring about this end functionally effective, and economical? As with all simple criteria, they are much easier to state than to apply. In other words, they have the limitations of any measuring-rods applied to human nature; but surely there is no one better equipped than the experienced physician to use them competently and wisely. He is specially informed as to the vagaries of human nature, and knows that there are those of us who are steady and predictable from our earliest years, whereas others are eccentric or whimsical. He is less apt to look upon any given behavior as an isolated phenomenon, but will rather place it within the background of the total personality. He knows what may reasonably be expected of Johnny Johnson or Sammy Smith, when the one is apt to get into trouble or when the other may be expected to achieve success. He knows a good deal about

* Read before the Section on Neuropsychiatry, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

knows about his individual patients as well. He can estimate the sum total of quirks and idiosyncrasies in his patients, and he knows that any sharp increase in the number of these indicates that something is afoot which may soon require special attention. If their actions are in accord with achieving what is for them a reasonable goal he need not be concerned; but if their actions are out of harmony with their potentialities, and no longer clearly effective and understandable in the light of the individual's personal history, the family physician is faced with the basic phenomenon of mental illness.

BEHAVIOR PROBLEMS OF CHILDREN

The clearest view of types of behavior which are abnormal can best be obtained by looking at the behavior problems of children. This is true not only because we all have a good idea of what to expect from any child of a given age but, also, because there is not a single symptom in the vast catalogue of psychopathology which does not have its roots in childhood and cannot be observed as a simply entity in the early years. The truth of the old adage that the child is father to the man is nowhere more forcefully exemplified than in the field of psychiatry. We must remember, however, that what may be a psychotic symptom in later years is not necessarily even abnormal in a child. It is a matter of degree and extent, and only when there is interference with the ordinary life of the child, or extreme concern on the part of the parents leading them to upset his usual way of doing things, do we speak of behavior disorder, or abnormality. While this warning may be pertinent in a psychiatric discussion, it is more usual to find that parents and doctors tend to minimize childhood maladjustments. In the hope that they will be outgrown, they are allowed to become fixed and progressively to handicap later development in increasing degree.

The most noticeable abnormal behavior in children is that characterized by a discrepancy between the type of action and what is ordinarily to be expected at a given age. We expect a baby to wet the bed, but not a 3-year old. We expect a 3-year old to attempt to trim the dog's ears with a pair of scissors, but not a 5-year old. We expect the 5-year old to ask to hear the old familiar story in preference to the new, but not the 9-year old. When we observe similar phenomena in adults, expressed in terms of goals and strivings, we speak of regression or fixation.

CLASSIFICATION OF BEHAVIOR DISORDERS OF CHILDREN

The behavior disorders of childhood can be broadly classified as those referable to the body and those referable to the outside world, the latter being what are known as social reactions. These disorders, with their derivatives and elaborations, constitute the symptomatology of adult life as well. So far as reactions referable to the body are concerned, we can name such as nail-biting, thumb-sucking, bed-wetting, failure in bowel training and body manipulations. These are the body attitudes which we find dominating the accounts of the childhood of the adult mentally-ill. The emphasis here should lie on the word "dominating," because all these reactions are also a part of normal development as well. The importance of degree takes precedence here over the importance of kind. It is only when these types of behavior become dominant and persistent, and interfere with development and the progression from one stage to the next, that they become of psychopathological importance. And a word of caution is appropriate here: all too often the suppression of a symptom, or unwanted type of behavior, is considered equivalent to eradication of the disorder itself. This is not the case. It is only when the symptom gives way to further developmental progress that it is eliminated; its suppression with the inevitable substitution by another, perhaps less obvious symptom, is not progress, but rather stagnation, and a mere postponement of the eventual settlement. All of these symptoms can be thought of in terms of time and energy wasted as well in terms of more elaborate theories of pleasure zones and psychosexual development; but the key to the problem is not the fact that they give gratification to the child, but that he desires this only in part. He himself is only too ready to forego whatever elemental pleasures may exist in these symptoms in favor of further development and the triumphs accompanying sublimation and achievement—provided he can find the road.

SYMPTOMATOLOGY OF SOCIAL REACTIONS

But let us turn to what we have referred to as the symptomatology of social reactions. Here we can name such behavior as withdrawal from the group, exaggerated dependence, inhibition of play, bullying, stealing, hates and resentments, and anxieties and phobias. Here again it is the degree of dominance and persistence that indicates the abnormal, rather than the particular content. And again we can say that it is not a preference on the part of the child that causes him to cling to the symptom. It is even more apparent here that even a minor triumph in the next developmental stage would be adequate compensation for relinquishing whatever pleasure might accompany the symptom. But it is again a question of finding the road. Whether dealing with children or with adults, it is safe to say that prohibition and correction serve no purpose. The problem of psychotherapy is always that of making available to the patient more adequate and more adult means of self-expression in terms of long-tested and socially acceptable modes. The patient who is completely trapped and deprived of adequate self-expression due to external limitations is probably nonexistent. In spite of what we have learned in recent years concerning the smallness of this globe whereon we exist, the

world is probably still a big enough place for the mature development of any one born into it.

This brings us back to the question of the purposefulness and usefulness of behavior, the economic attainment of an harmonious (egosyntonic) objective. This has been suggested as the criterion of mental health. One can see that it works out well when applied to these behavior disorders of children. It is also a therapeutic objective; but one can say very little concerning treatment in a paper designed to help the physician to recognize and understand these problems so that he can then apply his own common sense and experience to their solution. It is more profitable to go on to a brief consideration of the early symptomatology of mental illness in the period after childhood.

NEUROSES

The majority of mental cases that come to the attention of any doctor are the neuroses. The variety of clinical pictures presented are familiar to all of us. Once the physical health is assured the problem is to shift one's interest from the exaggeration and bizarreness of the complaints to the consideration of what they mean to the patient, and to the effect the illness has upon his successful functioning as a useful citizen. A surprising number of these milder mental illnesses find their way to hospitals eventually, and this outcome could often be prevented by sympathetic handling in the early stages, and by the patients being referred to a specialist at the moment it became obvious that symptoms were on the increase in spite of therapeutic efforts. The emphasis in recent years upon the psychosomatic concept in medicine has done much to help us realize that it is not the presence of gross, or microscopic, observable pathology that is important, but rather the functioning of the individual as a mind-body entity.

MANIC-DEPRESSIVE PSYCHOSIS

The family physician comes also into contact with the early stages of manic-depressive psychosis. The problem of recognition of mental illness is fairly simple here, but it is necessary to estimate correctly the extent of the illness and the speed of its progress. The manic phases move very rapidly, from the first indication that the patient's tremendous driving power is defeating his own ends to the point of helter-skelter activity with constant change of objective. The depressions move less rapidly, through minor complaints of mood change, insomnia, hypochondria and loss of weight, on to delusions and suicidal tendencies. The treatment in both types is essentially that provided by the mental hospital, but early recognition can markedly reduce the duration of illness.

DEMENTIA PRAECOX

The mental disease which fills far and away the largest proportion of hospital beds, and is also responsible for a great deal of economic failure, social unhappiness, and, also, many of our most sensational crimes, is dementia praecox, or what we have come to call the schizophrenias. The fact that the general public as well as the medical profession has become familiar with the descriptive, split-personality, does not make it any easier to recognize this disease in its early stages. The trouble is that these patients show so little upon which to base a diagnosis. The passive type, with his apparent lack of concern, or emotion, and the odd, impulsive type, with his emotional reactions out of proportion to the stimulus, are both difficult to recognize in their beginnings. But it is in just these cases that the criterion as to harmonious goal and effective action can be most helpful. The striking thing about the schizophrenic life-history is the apparent absence of understandable purposefulness in his behavior. Practically never do sensible goal and reasonable action coincide. Childish and even infantile behavior is prominent long before feelings of unreality and various types of hallucinations and delusions develop.

IN CONCLUSION

At the beginning of this paper I spoke of the difference in origin between psychiatry and the rest of medicine. There are other differences as well. One of these is the fact that pain, or fever, or a bleeding wound are known to all men. The doctor can identify directly with the suffering patient, and treat him with tenderness and sympathy. But to identify with and similarly treat a patient with mental disease requires a special psychological set. Every mental patient presents an inability or unwillingness to fit in with our social organization and could be considered either a rebel or a weakling. In fact the tendency so to consider him is something which must be overcome if one is to achieve the identification with the patient without which treatment cannot succeed. Another big difference between medicine and psychiatry is the fact that the former could take over directly the tools of physics and chemistry, and apply them to its progress. Psychiatry has had to forge its own tools and against inner as well as outer resistance. The insecurity of this position is obvious. We psychiatrists feel that we have the right to ask those who created us, the physicians in the other branches of medicine, to support us in our difficult task. We are more than pleased when we find other physicians interested in our work, and we shall do all in our power to increase this interest and to demonstrate the possible rewards in terms of community health which we believe our specialty to promise.

450 Sutter Street.

The wise man will live as long as he ought, not as long as he can. . . . He always reflects concerning the quality, and not the quantity, of his life.

—Seneca, *Epistulae ad Lucilium*. Epis. lux, 4. Quoted by Montaigne, *Essays*. Bk. ii, ch. 3.

CLINICAL NOTES AND CASE REPORTS

HEMATURIA AFTER MERCUROCHROME INSTILLATION INTO BLADDER

HARRY A. ZIDE, M. D. (M.C.)
AND
JACK C. HORNER, M. D. (M.C.)
Fort Ord

THE use of mercurochrome has been applied to various surgical procedures, as well as to bladder instillations after catheterization, in an effort to prevent postoperative infections and to aid postoperative voiding.[1] Reports of untoward reactions to this antiseptic are so infrequent that the occurrence of hematuria after instillation of 5 per cent aqueous mercurochrome solution is thought worthy of note.

REPORT OF CASE

CASE 1.—D. M. S., Reg. No. 15942, a white male, aged 27 years, was hospitalized at Station Hospital, Fort Ord, California, on February 11, 1942, for the treatment of a left indirect inguinal hernia of two months' duration. The past history was uneventful and the patient did not mention sensitivity to any drugs or chemicals.

During the preliminary examination, on February 16, the patient developed a left lobar pneumonia which was treated and cured with the aid of sulfathiazole, grams 44, over a period of three weeks. Urinalyses, prior to and during the administration of sulfathiazole, were normal in all respects.

On March 11, 1942, a herniaplasty was performed for the cure of the left inguinal hernia, using a spinal anesthetic, novocaine 100 mg. and nupercaine 2 c.c. The operation was uneventful. Following operation, the patient was unable to void and was catheterized in about 18 hours. Some 450 c.c. of clear urine were evacuated and 5 c.c. of 5 per cent aqueous mercurochrome solution was instilled before the catheter was removed.

The patient was able to void in about 8 hours, passing reddish urine. At this time an erythematous rash of the face and chest was noted. The operative site which had been painted with tincture of merthiolate showed no evidence of reaction. Urinary symptoms at the onset consisted of hourly frequency of voiding with severe burning during the act. The urine was noted to be grossly bloody. The patient was given bladder sedatives of tincture of belladonna and tincture of opium, together with pyridium tablets. There was a gradual relief of frequency and dysuria on this régime, which also included a moderate decrease in fluid intake in order to decrease bladder contractions. All symptoms had cleared by March 17, 1942, 6 days postoperative and approximately 5 days after the instillation of mercurochrome.

Urinalyses:

Feb. 14, 1942	(Preoperative)	Albumin neg., micros. neg.
Mar. 13, 1942	(2 days P.O.)	Alb. 4, packed with rbc.
Mar. 15, 1942	(4 days P.O.)	Alb. 4, packed with rbc.
Mar. 16, 1942	(5 days P.O.)	Alb. neg., numerous rbc.
Mar. 17, 1942	(6 days P.O.)	Alb. neg., several rbc.
Mar. 21, 1942	(10 days P.O.)	Alb. neg., micros. neg.

The urine output was normal throughout, while the postoperative temperature from March 11, 1942 to March 16, 1942, varied from 100 F. to 101 F., then gradually receded to normal on March 20, 1942.

Cystoscopy was performed on March 30, 1942, 19 days postoperative, using 5 per cent procaine intraurethrally as an anesthetic. The cystoscope, which had been sterilized in mercury-oxycyanide, was carefully washed with distilled water. Examination revealed a mild generalized cystitis, no other evidence of pathology being seen.

On March 31, 1942, the patient was skin-tested, with the application of a surgical solution of 2 per cent mercurochrome, on the inner aspect of the right forearm, and tincture merthiolate on the left forearm. In 12 hours there was slight redness about the edges of the mercurochrome patch, with no reaction where the merthiolate was applied.

Further questioning revealed that the patient had had eczema as a child. At the age of 21 years a mercurochrome salve was applied to the extremities for a skin infection; the application was followed by swelling of the extremities, as did a test application for sensitivity at a later date.

Upper urinary tract investigation was not done because of the past history of sensitivity to mercurochrome, the rapidity of onset of symptoms after instillation, and the clearance of symptoms as would be expected. Of course, any urinary bleeding in the future not definitely related to a drug reaction should have complete urographic study.

COMMENT

Reports of acute poisoning, after mercury-oxycyanide instillations following cystoscopy,[2] indicate the danger of that procedure; the reaction in the reported cases probably was due to a mercury intoxication rather than sensitivity. Hypersensitivity to mercurochrome by patch test was studied by Pascher and Silverberg,[3] who found that mercurochrome was the least likely of the mercury preparations to cause a dermatitis.

The importance of questioning patients as to sensitivity to drugs and antiseptic chemicals likely to be used in treatment is again brought out by this illustrative case, showing that even mercurochrome is not altogether innocuous.

Station Hospital, Fort Ord.

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1. Helfert, Irving and Granet, Emil: Prevention of Acute Retention Following Anorectal and Perineal Operations, Am. J. Surg., 53:125-126 (July), 1941.
2. Page, B. H., and Wilson, C.: Acute Poisoning After Cystoscopy, Lancet, 1:640-643 (April 6), 1940.
3. Pascher, Frances and Silverberg, M. G.: Hypersensitivity to Mercurochrome by Patch Test, Arch. Derm. and Syph., 27:408-410 (March), 1933.

"These are the times that try men's souls; the Summer Soldier and the Sunshine Patriot will, in this crisis, shrink from the service of his country, but he that stands it now deserves the love and thanks of Man and Woman."—Thomas Paine.

"This war is going to alter radically the lives of every one of us. It not only will alter our lives during the immediate years after the war, but it will alter the life on this planet throughout our lives and the lives of our children. And whether it is going to be the kind of a life in its influences and in its developments that we want it to be, and is going to be the kind of a life that will give us the most satisfaction in having lived, is going to be dependent on how we utilize these years that are right here now—on our understanding of what are the necessities of a post-war world."—Dr. Ernest Martin Hopkins, President, Dartmouth College.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL CALL

To the Officers and Members of the California Medical Association:

The seventy-second annual session of the California Medical Association will be held at Hotel Biltmore, in Los Angeles, on Sunday, May 2nd, and Monday, May 3rd, Nineteen hundred and forty-three.

The House of Delegates will convene on Sunday, May 2nd, at 12:00 o'clock noon.

The Scientific Assembly of the Association will open with the General Meeting, held on Sunday, May 2nd, at 9:00 A.M. General Meetings will also be held on Sunday afternoon and Monday morning.

The Council will convene for its first annual session meeting on Saturday, May 1st.

The twelve Scientific Sections of the Scientific Assembly will meet Monday afternoon, May 3rd, at 1:30 o'clock.

WILLIAM R. MOLONY, SR., *President.*
LOWELL S. GOIN, *Speaker, House of Delegates.*
PHILIP K. GILMAN, *Chairman, Council.*

ATTEST:
GEORGE H. KRESS, *Secretary.*
San Francisco, California, February 23, 1943.

OFFICIAL NOTICE

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Abstract of Minutes: California Medical Association Executive Committee*

Minutes of the One Hundred Eightieth (180th) Meeting of the Executive Committee of the California Medical Association

The one hundred eightieth (180th) meeting of the C.M.A. Executive Committee was held in the offices of the Association, 450 Sutter Building, San Francisco, on Sunday, February 7, 1943, the meeting being called to order at 11:00 a.m. by Chairman Henry S. Rogers.

1. **Roll Call:**

Present: Henry S. Rogers, Chairman; William R. Molony, Sr., Karl L. Schaupp, Lowell S. Goin, Philip K. Gilman, John W. Cline, George H. Kress.

Present by invitation: Executive Secretary John Hunton, Legal Counsel Hartley F. Peart, and Associate Counsel, Mr. Howard Hassard.

2. **Minutes:**

Minutes of the one hundred seventy-ninth meeting of the C.M.A. Executive Committee, printed in the January issue of CALIFORNIA AND WESTERN MEDICINE on pages 21-23, were approved.

3. **Membership:**

(a) Report was made by Executive Secretary Hunton on membership, as of January 30, 1943, the same being received and filed.

(b) A list of some six members, whose dues for 1942 were paid subsequent to September 13, 1942, was submitted, and on motion duly made and seconded, it was voted that the aforesaid members be reinstated into membership.

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

(c) On motion duly made and seconded, it was voted that Retired Membership be granted to the following members:

H. L. McCarthy, M. D., Los Angeles County.
Charles E. Sisson, M. D., Los Angeles County.
Lewis Sayre Mace, M. D., San Francisco County.
Horace G. Lazelle, M. D., San Diego County.

(d) Yolo County Medical Society submitted the name of W. J. Blevins, M. D., for Life Membership; and on motion duly made and seconded, the same was granted.

(e) Discussion took place on whether members of the Association who were in the U. S. Public Health Service should be exempted from payment of State Association dues. It was agreed that the Legal Counsel should prepare a report thereon for submittal at the Council meeting of February 28th.

4. **Financial:**

(a) A report was made by Executive Secretary Hunton on finances, as of January 30, 1943, and the same was received and placed on file.

(b) It was reported that the Basic Science campaign had necessitated the expenditure of $6,918.63 in excess of previous appropriations. On motion duly made and seconded, it was voted that the same be approved.

(c) The possible need of the sum of $2,000 as a budget allocation for assistance in the work of "Medical Participation in the War Effort," with particular reference to Procurement and Assignment Service requirements, was discussed. It was agreed that this matter should lie over for consideration by the Council.

(d) It was voted that the sum of $15,000 be transferred from the funds of the California Medical Association as part payment on a loan that had been granted by the Trustees of the California Medical Association. (Repayment to Trustees.)

(e) The Auditing Committee, through its Chairman, John Cline, submitted a proposed budget for the calendar year 1944. Discussion followed. Upon motion duly made and seconded, it was voted to approve the report of the Auditing Committee, and to submit the same to the Council at its meeting on February 28th.

5. **Annual Session:**

For the Committee on Scientific Work, its Chairman, Dr. Kress, made report concerning the tentative outline for this year's Annual Session, to be held in Hotel Biltmore, Los Angeles, May 2-3, 1943.

The skeleton arrangement comprehends three General Sessions, the first on Sunday morning, May 2nd, for organization and some scientific work; the second on Sunday afternoon, and the third on Monday morning. All meetings of Scientific Sections will be held on Monday afternoon.

The major topics agreed upon were to come under the following heads:

(a) Communicable Diseases (emphasis on tropical and other wartime infections.)

(b) Practical points in civilian disaster relief (shock, burns and other related matters.)

(c) Nutrition Problems (good nutrition despite food shortage, etc.)

(d) New Problems in Wartime Industry.

The C.M.A. Committee on Scientific Work also recommended that three guest speakers be invited in accord with past custom, and it was so voted.

It was stated that military colleagues attached to some of the hospitals and camps in California, who had been contacted, had expressed willingness to take part and report on some of the more recent work.

6. **Report on "Doctor Shortage" Questionnaires:**

Report was submitted on the replies which had been received from component county medical societies concerning doctor shortage in their respective areas. The report indicated that serious shortages existed in only a very small number of cases.

It was stated that reports thus far not submitted should be available within the next 10 days, so that a break-down and full report could be made for the Council meeting on February 28th.

7. **Amendments to Medical Practice Act:**

For the Committee on Legislation, report was made that the California Medical Association had submitted no amendments to the Medical Practice Act at the January Session of the Legislature; further, that the Board of Medical Examiners had taken the matter in hand through amendments that would permit examinations to be more frequently held by committees of the Board, with provision that mail vote of the entire Board could be promptly taken, so that licensure of qualified physicians could be expedited.

8. **Vacancies on State Boards:**

Informal discussion took place concerning vacancies on the State Board of Medical Examiners and the State Board of Public Health.

9. **Annual Conference of County Association Secretaries:**

The Association Secretary reported that a mail vote of the Council was in favor of not holding, in the year 1943, a conference meeting of the Secretaries of component county societies, Chairmen of State Association committees, and Officers of the Association.

10. **Distribution of Professional Service—Industrial Accident Commission:**

President Molony brought up for consideration a recent New York law concerning industrial commission work which had as its object a more equitable distribution of professional service among licensed physicians. General discussion followed. Dr. Cline spoke of the investigations that had been made in the last two years and called attention to some of the difficulties that had been encountered in trying to work out panels of available physicians in such manner as to be satisfactory to all interested, and at the same time make for a betterment of existing conditions. He stated that in the last and present Legislatures, bills had been submitted with such objectives in view.

President Molony added he would strive to obtain more detailed information from colleagues in New York.

11. **Fee Schedule—Industrial Accident Commission:**

Legal Counsel Peart reported on conferences that had been held during the last month with representatives of the Industrial Accident Commission, specialty groups, and others. He stated that the papers and proposed fee tables had been filed with the Industrial Accident Commission, and would come up for public hearing on February 15, 1943.

Mr. Peart outlined the reasons on which the petition for increase in professional fee rates was based.

12. **California Physicians' Service and Hospital Service of California: Proposed Survey of Medical Service and Hospitalization Plans:**

Discussion then took place on the special purpose of the present Executive Committee meeting, namely, the situation which had arisen in relation to California Physicians' Service and Hospital Service of California (Oakland), through action by the medical service organization taking on hospitalization care, and the hospitalization organization offering contracts for medical service.

The history of the proceedings that had led up to the now existing conditions was covered by several speakers in order that all should have a proper orientation of the

situation. It was finally agreed that some of the things that had taken place could not now be easily rectified, the problem being as to what could be done immediately in bringing about an improvement of conditions that were not working to the best interests of the medical profession or of the organizations.

In the discussion, it was brought out that on February 8th, the American Hospital Association would hold a meeting in Chicago, and it was possible that the California situation might come up for consideration.

Council Chairman Gilman called attention to some informal conferences that had been held at which it had been suggested that it might be advisable to bring to California some person experienced in medical service and hospitalization plan work, to make a survey of existing conditions and to bring in a report thereon.

Some informal communications dealing with this matter were then submitted, the same being placed in the filed.

It was pointed out that California Physicians' Service had offered hospitalization contracts, that Hospital Service of California was offering medical indemnity contracts, that the existing set-up made for duplication, and was not conducive to attainment of the major objectives which the California Medical Association had in mind when California Physicians' Service was brought into being.

Full discussion took place on what would be the advantages of a survey, and, if a survey were to be made, under what conditions the same should be conducted, and who would be the person selected for the task.

Motion was made by Goin, seconded by Cline, that if a survey were made, the same should cover a definite task; a date for its completion should be stipulated; and whoever was selected to make the survey should be employed by the California Medical Association; that the survey would automatically become the property of the California Medical Association; and that the survey could not be published except by the California Medical Association or with its permission. This motion was tabled to allow further discussion.

Upon motion by Gilman, seconded by Cline, it was voted that the survey, insofar as concerns C.P.S., should be limited to the private activities of C.P.S., its Governmental activities not to be a subject coming within the scope of the survey.

Vote was then taken on the original motion by Dr. Goin which had been tabled. It was voted to reconsider the items therein.

Upon motion by Cline, seconded by Schaupp, it was then voted as follows: that any agreement made with the person designated to make the survey should be in writing; that the scope of the survey should be confined to the respective activities of medical service and hospitalization plans, and how the same may be promoted to best advantage of the organizations involved and the public welfare.

It was voted that, for the purpose of making the survey, and while making the survey, any person employed should be the representative of the California Medical Association.

It was voted that, in making the survey, the surveyor should be governed in his statements concerning the respective spheres of medical service and hospitalization care by the definitions of hospital care as have been laid down by the A.M.A. House of Delegates.

Upon motion by Cline, it was voted that the maximum cost of the survey be limited to $1,500 and the same to be completed within 60 days from February 8th.

On motion by Cline, seconded by Schaupp, it was voted that John Mannix of the Michigan Medical Service be invited to make a survey under conditions as outlined.

Discussion then took place concerning various persons other than John Mannix who were worthy of consideration for such work, the names of two others being mentioned. Motion was made by Dr. Goin that the name of one of those be substituted. The motion did not receive a second. The vote to employ Mr. Mannix was in favor thereof, but Dr. Goin wished his vote recorded in the negative.

On motion made by Goin, duly seconded, it was voted that when and if Hospital Service of California confines itself to hospitalization care, then California Physicians' Service should confine its work to private beneficiary members for medical service.

There being no further business, adjournment then took place.

HENRY S. ROGERS, M. D., *Chairman.*
GEORGE H. KRESS, M. D., *Secretary.*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Medical Journals—For Colleagues in Military Service:

In former issues editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U.S.N. The Senior Medical Officer is Captain John C. Ruddock, U.S.N.R. The office is located at 411 West Fifth Street, N.W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

PRO PATRIA

THREE LETTERS FROM SAN FRANCISCO COLLEAGUES

Note. The Editor will be pleased to receive letters from C.M.A. members, who in turn have heard from colleagues in military service. (The original letters will be returned after "copy" has been set in print.)

Members of the Association, who are in service with the Armed Forces in the United States or elsewhere, are also invited to write the Editor concerning their experiences. Colleagues in civilian practice will be happy to hear from you.—Ed.

* * *

(COPY)

From Lt. F. H. Moore, M.C., Marine Corps Unit 725, Fleet Postmaster, S. F.

Guadalcanal, December 9, 1942.

Dear Cobbie:

Just a line to say hello from the Solomons. Was attached to the Marine Aircraft Wing early in October, left San Diego on October 15th and landed in New Caledonia October 28th. After a month there, I was flown up here and am in charge of evacuating sick and wounded by transport planes to base hospitals in safer areas. Am also in charge of a Squadron. Have a swell job, and am sure you would get a kick out of seeing these big air ambulances haul our patients out.

Things are relatively quiet now, although we have had several heavy naval engagements offshore which we could hear, and one night bombing. The land fighting goes on right along with our Marines pushing ahead, bit by bit, in jungle fighting. I went up within 400 yards of the front lines this morning and saw many Jap dugouts which had been recently taken, with a little earth dumped over the previous occupants; and many items such as shoes, helmets, knapsacks, and gas masks still lying about. Could hear desultory gun fire up ahead all along.

On December 7th I went around with Arthur Menken, the famous war correspondent and now Marine Photographer, to photograph an anniversary shelling of the Jap positions. We saw a whole afternoon of it—75s, 105s, 155s, and mortars. I imagine it didn't seem funny to the Japs as it did a year ago.

Today was over at the prisoner's stockade and saw about 30 rather sullen Nipponese who didn't realize their luck in being alive and eating Yankee food. The gate to the stockade is left wide open and a Marine with a tommy gun sits hopefully in front of it.

Have seen quite a bit of bacillary dysentery and subtertian malaria, hence sulfeguanidine, atabrin, and quinine are the big drugs. The weather is hot 4+ and humid 4++, so one drips most of the time. My tent and First Aid Station is right in jungle. Boy, when I was in practice in San Francisco, was I ever an internist? Not now!

I am enclosing a snapshot taken in front of the famous hill on which the Jap flag flew,—now the old Stars and Stripes wave there, and I never fail to thrill at it when I see our flag.

Hope all goes well with the bunch at 384 Post, and wish you would tell them hello for me. . . .

Your friend,

FERRALL.

Trust you have heard good news from John by now.

(COPY)

From Major R. F. Escamilla, 59th Evacuation Hospital, APO-668—New York, N. Y.

Somewhere in Africa, January 27, 1942.

Dear Al:

When I crawl into my sleeping bag at night, and the African Sirocco makes the tent flap, and my mosquito netting bounces up and down, I often wonder how the hell things are going back in San Francisco. I would appreciate it very much if you would write me a letter once in a while—full of news, especially about my old friends there. The mail seems to move in very slowly, so suggest air-mail, if you do find time to write. . . .

Africa is interesting, but up to the time of this writing, where I am, we are not busy enough to keep from being bored most of the time. The trip across was comfortable and uneventful, and the only sign of war so far has been one very minor air-raid. Our hospital is partially open, under tents, but most of our cases are convalescent; so—from our point of view—not very exciting. Local humor is so far practically nonexistent. However, I have picked up one ditty about "Dirty Gertie from Dizerta," that I'll save for my first evening back at the Family Club.

Remember me to the gang, and tell the home docs that we don't want any new ways to practice medicine when we get back.

Best wishes,

(Signed) BOB.

From Major Paul C. Sampson, Lawson General Hospital, Atlanta, Ga.

(COPY)

2nd Aux. Surg. Gp.
LAWSON GENERAL HOSPITAL
Atlanta, Georgia

February 16, 1943.

Dear Doctor Kress:

It was indeed good to hear from you—and I certainly appreciate your prompt and favorable consideration of my little contribution to C. and W. M.

Those of us who are about to leave for parts unknown are more appreciative than we can say of the thoughts and good wishes of you on the home front. We do thank you—and hope that our pleasant and cordial friendship can be renewed in the days to come.

Most sincerely,

PAUL C. SAMPSON, *Major, M.C.*

Irwin Blood Bank of San Francisco County Medical Society Donates Huge Amount of Plasma

The Irwin Memorial Blood Bank donated 1,382 bottles of life-saving plasma, worth over $33,000 at commercial prices, to San Francisco hospitals as disaster protection during the past year.

In addition to creation of an emergency supply of plasma for use in the event of any major disaster, the year-end report of the San Francisco County Medical Society's Blood Bank Commission disclosed the Irwin Blood Bank regularly supplied whole blood at cost to twenty hospitals in San Francisco and twelve hospitals in the adjacent area. During the year 5,785 pints of whole blood were dispensed in this program.

To cut the time of drying plasma from the present four days to twenty-four hours, the blood bank will receive next month a new combined plasma "sheller, freezer, and dryer." Now being tested in Chicago, the first ten such mechanisms in the United States are nearly ready for distribution.

In a Hospital On Guadalcanal—

200 Yards from the Front, Your Blood Helps Beat the Enemy

Guadalcanal, Nov. 30.— (Delayed) — Since daybreak United States Marines have been pushing through the swamp and jungle. The tirade of machine guns, viciously punctuated by fire from enemy field pieces, has taken its toll during the fiercely fought battle.

Only 200 yards behind the front line, another battle is being fought. The Navy Medical Corps, attached to the Marine unit is working against death. The advance dressing station, with its group of stretchers and litter of medical supplies, is pitched where the trees offer maximum protection and cover.

As the doctors and corpsmen work intently, six men struggle through the jungle trail to the station with a stretcher. They are carrying a Marine whose arm has been torn off by machine gun fire. To this lay eye he appears lifeless.

A doctor produces two small flasks. One is filled with distilled water; the other with a substance that looks like fine sawdust. Quickly the water is drawn by vacuum into the second flask, forming a straw-colored liquid. The doctor agitates the flask to dissolve all the sawdust-like substance. Then deft hands jab a needle into the Marine's limp veins, and slowly the liquid drains through a rubber tube.

Perhaps the process has taken eight minutes, perhaps fifteen. Visibly the color comes back into the man's face; perceptibly his pulse quickens and his body regains its heat. The regeneration is complete.

The work of the field doctors is done. One more live Marine will go back to the base hospital where he will receive all the refinements of hospital care.

Out in the field, the Navy Medical Corps swears by the desiccated blood plasma. It has been established beyond all reasonable doubt that a great number of field casualties would have died from shock or loss of blood had it not been for this simple transfusion.

In 10 weeks of action, during which over 100 casualties were treated in his advance dressing station, one doctor reports he has only lost three men. The answer he gives: Plasma.

The doctors in Guadalcanal tell many stories of its effectiveness. Lieutenant Commander William N. New (MC), U.S.N., of Guthrie, Okla., chief surgeon for this force of Marines, said, "The other day four men in very bad shape were brought into the sick bay. Those four were definitely saved by emergency transfusions."...

Plasma is easy to carry and easy to administer, even with the limited facilities of an advance dressing station. Doctors prefer to give the plasma transfusions themselves, but agree corpsmen are perfectly capable of administering it.

It can be given to any blood type because it is compounded from a stockpile of all types.

"Plasma is one of the great developments of wartime medicine," said Dr. New. "We can never have enough of it."—San Francisco *Chronicle*.

* * *

Wartime Control of Venereal Diseases: Rôle of Pharmacists

Pharmacists are playing an important rôle in the wartime control of venereal diseases, the American Social Hygiene Association announced recently, in making available to the medical profession a report based on a recently completed survey.

Drug store counter prescribing for syphilis and gonorrhea has greatly decreased, the Association reports. Forty-six cities in fifteen States were visited, and 716 drug stores studied. Only 11 per cent of the drug stores visited offered diagnosis and treatment for conditions presumed to be syphilis and gonorrhea. Thirty-two per cent sold remedies on specific request but did not attempt to diagnose, and 57 per cent urged immediate and well qualified medical care, and in a large proportion of the drug stores where remedies are stocked and sold, the druggist advised that "self-medication is bad and dangerous business."

This survey showed a decided improvement over conditions found in 1939 and 1940. . . .

The report of the survey was published in "Venereal Disease Information" in January, 1940. It received wide publicity and led to the formation of the Joint Committee of the American Pharmaceutical Association and the American Social Hygiene Association, organized to bring about closer coöperation between physicians and the pharmacists in eradicating syphilis and gonorrhea. This committee has constantly urged druggists to follow, with reference to venereal diseases, the principles of ethical practice enumerated below:

1. The pharmacist should make no diagnosis.
2. The pharmacist should not prescribe for patients.
3. The pharmacist should refer patients to physicians.
4. The pharmacist should not sell "patent medicines" and thus encourage self-medication of these infectious diseases.
5. The pharmacist should distribute literature of an informational nature regarding syphilis and gonorrhea. Such material may be obtained from health departments and from the American Social Hygiene Association.
6. The pharmacist should coöperate with the pharmaceutical society and official and voluntary health agencies in promoting high professional standards.
7. The pharmacist should stock and sell only reliable products for chemical and mechanical prophylaxis of venereal diseases, and provide reliable information regarding the value and limitations of accepted prophylactics used under approved conditions.

When subsequent soundings were made during 1940 in many of the thirty-five cities originally studied, a decided trend away from the former conditions was discernible. In many drug stores where diagnosis and treatment had been offered, counter prescribing and the sale of nostrums were no longer practiced. In their places many druggists recommended competent physicians and various venereal disease clinics. This trend away from counter prescribing for venereal diseases has continued as proven by the recent 1942 survey.

Military Clippings—Some news items of a military nature from the daily press follow:

Medical Science Saves Lives

A happier and encouraging picture for the New Year are the figures on saving the lives of men wounded in battle in World War II. Rear Admiral Ross T. McIntire, Navy's Surgeon General, recently told the medical students of Northwestern University that the Russians claim an astounding record in saving the wounded—only 1.5 per cent, exclusive of those killed in battle, die of their wounds. For the U. S., the record is even better, though on a smaller scale. On Guadalcanal, less than 1 per cent have died, compared to 7 per cent in World War I. In one specific type of wound, the percentage is amazing—only 5 per cent die as against 70 per cent to 80 per cent in World War I.

Due to these splendid advances in medical treatment, many a boy will return home who might otherwise have died.—Porterville *Recorder*, January 19.

State Draft Boards: Warren Gives Courts Final Say On New Appointments

Removal of all politics from the selection of local, advisory and appeal draft boards throughout California was announced yesterday by Governor Warren.

Hereafter, a policy will be followed of making all appointments subject to recommendation by Superior and Appellate Judges before they are forwarded to President Roosevelt for his formal action.

"It is not my intention to disturb existing local boards, appeal boards or other personnel presently engaged in the administration of selective service in California," said the Governor.

He said he was clarifying "the atmosphere in regard to procedure for filling actual vacancies which require recommendation or appointment by the Governor."

Warren asked Chief Justice Phil S. Gibson of the State Supreme Court for the support and coöperation of the Judicial Council, of which Gibson is chairman. He said: "It is my belief that the Judges and Justices will submit names without regard to politics, color, race or creed and solely on the basis of character and ability to perform the task."

Whenever a vacancy occurs on a local draft board, Warren said, the presiding Superior Court Judge in the county will recommend a successor. Whenever a chairman of the advisory board for registrants resigns, the Superior Judge will recommend the name of a new chairman under Warren's plan.

Vacancies on appeal boards will be filled by recommendations from Justices of the District Courts of Appeal.

"I am doing this," said the Governor, "because the personnel of such boards is a matter of community concern, and therefore selection of membership should be left as much as possible in the hands of those thoroughly familiar with local conditions."

The Governor said 39 vacancies exist among the 284 local draft boards and four vacancies on the 20 appeal boards throughout the State.

Warren also is asking the State Bar to recommend appointments as appeal agents and associate appeal agents, the various county medical societies to recommend examining physicians and medical advisory board members, and the California Dental Association to recommend examining dentists. . . . —San Francisco *Chronicle*, February 11.

State Medical Rating High

California is still receiving a high standard of medical care and will continue to receive it, according to Dr. William R. Molony, Sr., president of the California Medical Association.

"A survey just completed by the California Medical Association shows that with very few exceptions the communities of this State have enough doctors to give the civilian population adequate medical care, Dr. Molony stated.

By pooling the efforts of doctors for emergencies and the relocation of physicians in rural districts, any shortage may be handled, he said.—Los Angeles *Examiner*, January 24.

Adequate Medical Help Is Promised Civilians

For the guidance of the civilian, Dr. Frank H. Lahey, chairman of the directing board, procurement and assignment service for physicians and veterinarians of the War Manpower Commission, recently laid down some simple rules, which he suggests be posted in some conspicuous place in every home:

1. Keep healthy. Get plenty of sleep, eat the proper foods, get plenty of fresh air, exercise and recreation.

2. Avoid unnecessary demands on the physician's time whenever possible; go to his office during office hours instead of asking him to call upon you at your home.

3. In case of really serious illness, do not delay in calling your doctor or calling at his office. It will save his time, if he is called promptly in any case of acute illness. This is not a contradiction of Point 2. It does, however, assume that the average citizen has good judgment. In doubtful cases, call the doctor at once.

4. Avail yourself of opportunities to study first aid, in order to know how to give care to the injured until such time as a doctor can take over.

5. In connection with Point 1, if you do not know the basic rules of nutrition, avail yourself of opportunities to learn the facts.

Yes, we know the physicians at home will do their part in assuming the added burdens imposed on them by the depletion in their ranks.

The civilian population should do its part as well.—Sacramento *Bee*, January 21.

Casualty Plan Calls Doctors

To carry out an elaborate program for hospitalization of civilian casualties of enemy raids or sabotage, 13 outstanding Southern California physicians are to be made Army officers and will be assigned to active duty in case of emergency.

This was announced here today by Dr. Charles F. Sebastian, chief medical officer in the Southern California sector for the United States Public Health Service, under assignment to the Office of Civilian Defense.

Numerous base hospitals will be set up in this sector for accommodating raid or sabotage victims and existing hospitals will also be used, Dr. Sebastian said.

Several hotel properties have been surveyed by the Army, it was also learned, with the view to condemning them in case of emergency, and using them as military hospitals.

Regular patients of hospitals will be moved to protected inland points, in case of such emergency, Dr. Sebastian said, with the government handling expenses of such a move.

The physicians selected met here yesterday for the first time to confer with Dr. Sebastian on completion of plans. Those from the Los Angeles area who have been chosen are Dr. Donald Cass, Dr. Sidney Burnap, Dr. Forrest Boyd, Dr. Howard West, Dr. George Piness, Dr. Phillip Cunnane, Dr. Fred B. Moor and Dr. Leroy Sherry, Pasadena.—Los Angeles *Herald and Express*, February 4.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

California Legislature—55th Session

The Public Health League of California has made a list of proposed laws having relation to medical and public health practice and standards. A glance at the summary reveals the large number of such proposed statutes, even though the 55th is a streamlined legislature with a record of 1,000 less bills introduced than in each of the last several sessions.

Members of the C.M.A. may wish to take the time to glance through the list. Further information can be obtained from the Secretary of the Public Health League, Mr. Ben Read, whose address appears in each issue of CALIFORNIA AND WESTERN MEDICINE, in the roster on advertising page 6.

Abbrevations:
AB means Assembly Bill.
SB means Senate Bill.

Chiropody (five bills).

AB 334, by Evans (referred to Committee on Public Health), extends definition of chiropody to include treatment of the leg. Prohibits recommendation of corrective shoes or appliances by persons other than physicians and surgeons and chiropodists.

AB 355, by Evans (referred to Committee on Public Health), permits supplying of hypodermic needles or syringes to chiropodists.

AB 1110, by Waters, Debs and Fourt (referred to Committee on Public Health), establishes State Chiropody Act, sets up California Chiropody Society to take over examinations and issuing of licenses to practice Chiropody, now under direction of State Board of Medical Examiners.

AB 1928, by Call (referred to Committee on Public Health), adds chiropody and chiropodists to sections of Health and Safety Code, Labor Code and School Code, relating to rights and privileges of physicians, surgeons, dentists, optometrists, osteopaths, chiropractors and veterinarians.

SB 596, by Shelley (referred to Committee on Business and Professions), companion bill to AB 1110.

* * *

Chiropractic (five bills).

AB 1831, by Clayton A. Dills (referred to Committee on Public Health), permits chiropractors to treat injured employees under Workmen's Compensation Act.

AB 1832, by Clayton A. Dills (referred to Committee on Public Health), relating to graduate physicians. Permits chiropractors to take graduate course of 600 hours and receive degree of graduate physician and use title of "physician."

See also AB 1830, 1833 and 1841.

* * *

Dentistry (seven bills).

AB 1465, by Debs, Howser and Wollenberg (referred to

Committee on Public Health), relating to disciplinary powers of State Board of Dental Examiners.

AB 1466, by Debs, Howser and Wollenberg (referred to Committee on Public Health), relating to appointments to Board of Dental Examiners. Governor shall make appointments from list of four names for each vacancy, submitted by secretaries of California State Dental Association and Southern California State Dental Association.

AB 1467, by Debs, Howser and Wollenberg (referred to Committee on Public Health), relating to temporary licenses to practice Dentistry.

AB 1468, by Debs, Howser and Wollenberg (referred to Committee on Public Health), relating to the oath on an affidavit of a complainant on an accusation.

AB 1469, by Debs, Howser and Wollenberg (referred to Committee on Public Health), advertising or solicitation to furnish dental treatment by mail shall constitute unprofessional conduct.

AB 1575, by O'Day (referred to Committee on Public Health), relating to disciplinary proceedings in connection with "chain store" offices.

AB 1576, by O'Day (referred to Committee on Puhlic Health), person conducting dental office in his or her name shall be personally present in such office operating as a dentist or personally overseeing such operations, during a majority of the time said office or offices are being operated.

Above bills are sponsored by the California State Dental Association and the Southern California State Dental Association.

* * *

Disability Insurance (one bill).

SB 879, by Shelley (referred to Committee on Welfare and Institutions), amending the Unemployment Insurance Act to establish a system of Disability Unemployment Insurance.

* * *

Drugs and Foods (four bills).

AB 667, by Potter (referred to Committee on Public Health), relating to the adulteration, misbranding, advertising and sale of drugs and devices, and to the powers of the State Department of Public Health in relation thereto.

AB 970, by Hawkins (referred to Committee on Public Health), relating to the adulteration of drugs and devices.

AB 1824, by Lyon (referred to Committee on Public Health), relating to adulteration or misbranding or false advertising of foods.

SB 423, by Burns (referred to Committee on Public Health and Safety), relating to adultering, mislabeling, misbranding, false advertising and sale of foods, and the powers of the State Department of Public Health in relation thereto.

* * *

Drugless Practitioners (one bill).

AB 573, by Desmond (referred to Committee on Public Health), removes drugless practitioners from supervision of Board of Medical Examiners.

* * *

Handicapped Children (six bills).

AB 91, by Thomas (referred to Committee on Education), relating to the establishment of a residential school for the hard of hearing children of school age, and making an appropriation therefor.

AB 257, by Gannon, Kellems, Massion, Doyle, Ralph C. Dills, Clayton A. Dills, Kraft, Debs, Dunn, Burkhalter, Brady, Lowrey, Price, Thurman, Brown, Haggerty and Wollenberg (referred to Committee on Social Welfare), relating to children with an impaired sense of hearing and making an appropriation of $26,500.

AB 665, by Potter (referred to Committee on Public Health), relating to services for physically handicapped children, providing for receipt and administration of Federal Funds, providing for coöperation with the Federal Government.

AB 1557, by Potter (referred to Committee on Social Welfare), appropriating $100,000 to the State Department of Public Health for services to physically handicapped children.

AB 1717, by Robertson (referred to Committee on Social Welfare), an act to provide facilities to discover children with impaired sense of hearing and making an appropriation of $26,500 therefor.

SB 451, by Burns (referred to Committee on Public Health and Safety), companion bill to AB 665.

Health Insurance (two bills).

AB 1079, by Hawkins (referred to Committee on Finance and Insurance), amending Unemployment Insurance Act to include a system of health insurance within the system of unemployment insurance. This act to be known as the Social Insurance Act.

SB 885, by Swan (referred to Committee on Welfare and Institutions), companion bill to AB 1079.

* * *

Hospitals (fourteen bills).

AB 152, by Johnson (referred to Committee on Universities and Colleges), appropriating $2,000,000 for the erection and equipment of a hospital to be maintained and supported in conjunction with the medical school of the University of California.

AB 227, by Debs and Potter (referred to Committee on Judiciary), relating to the liability of innkeepers, to include hospitals.

AB 228, by Debs and Potter (referred to Committee on Judiciary), relating to personal property left in hotel, etc., to include hospitals.

AB 325, by Potter and John C. Lyons (referred to Committee on Public Health), relating to the disposition of assets of nonprofit corporations upon dissolution or winding up.

AB 327, by Potter and Kraft (referred to Committee on Public Health), relating to applicability of clinic and dispensary licensing provisions.

AB 328, by Potter and Kraft (referred to Committee on Judiciary), hospital lien bill. Providing for liens in favor of private hospitals in this State upon all causes of action for damages accruing to an injured person therein or to the legal representatives of such person for the reasonable charges for hospital care, treatment and maintenance necessitated by the injuries giving rise to such causes of action.

AB 329, by Potter and Hollibaugh (referred to Committee on Public Health), relating to indigent aid, including contracts for care of indigents, emergency services authorized; nonemergency services authorized; hospitals with which agreements may be made.

AB 330, by Potter and Haggerty (referred to Committee on Judiciary), relating to exemptions from restrictions on devises or bequests.

AB 530, by Gaffney, Berry, Brady, Haggerty and George D. Collins (referred to Committee on Governmental Efficiency and Economy), relating to the management of hospitals for which charges are demanded, collected or received by an employer.

AB 965, by Dunn (referred to Committee on Labor and Capital), relating to the furnishing of hospital services by employers to employees and former employees.

AB 1334, by Kraft, Debs, Stream and Potter (referred to Committee on Finance and Insurance), amending the Unemployment Insurance Act relating to exemptions.

AB 1618, by Howser (referred to Committee on Social Welfare), relating to payment by a responsible county or county of residence for hospital care rendered to an indigent person by another county.

ACA 17, by Potter and 66 other Assemblymen (referred to Committee on Constitutional Amendments), Legislature may exempt from taxation property owned and used for charitable purposes.

SB 499, by DeLap (referred to Committee on Welfare and Institutions), relating to county contracts for hospital care and services.

SB 1026, by Ward (referred to Committee on Welfare and Institutions), companion bill to AB 1334.

AB 227, 228, 325, 327, 328, 329, 330, 1334, ACA 17, and SB 1026 are sponsored by the Association of California Hospitals.

Hospital Service (two bills).

AB 1014, by Maloney, Miller and Haggerty (referred to Committee on Finance and Insurance), relating to medical and hospital reimbursement benefits.

AB 1015, by Maloney, Miller and Haggerty (referred to Committee on Finance and Insurance), amending the Insurance Code relating to "hospital services."

* * *

Licenses (one bill).

AB 1627, by Dickey (referred to Committee on Governmental Efficiency and Economy), relating to renewal of licenses of persons who have served in the armed forces, by boards or commissions of the Department of Professional and Vocational Standards.

Massage (one bill).

AB 528, by McMillan and Middough (referred to Committee on Public Health), establishing a California State Board of Massage.

Medical Examiners, Board of (six bills).

AB 1171, by Potter (referred to Committee on Public Health), relating to issuing of certificates, providing for committees to examine applicants and board may vote by mail.

AB 1172, by Potter (referred to Committee on Public Health), relating to disciplinary procedure.

AB 1173, by Potter (referred to Committee on Public Health), relating to immunity of witnesses in disciplinary proceedings.

AB 1174, by Potter (referred to Committee on Public Health), relating to reinstatement of certificates to practice medicine.

AB 1175, by Potter (referred to Committee on Public Health), relating to the proof of the completion of instruction and training requirements to practice medicine.

Above bills are sponsored by the Board of Medical Examiners.

SB 589, by Tenney (referred to Committee on Business and Professions), establishing subversive activities as cause for denial, suspension or revocation of licenses to practice medicine.

* * *

Mentally Irresponsible (thirty-seven bills).

AB 383, 423, 430, 447, 448, 466, 594, 595, 596, 886, 1041, 1116, 1144, 1181, 1182, 1184, 1186, 1187, 1188, 1189, 1190, 1191, 1192, 1193, 1194, 1195, 1196, 1197, 1198, 1340, 1341, 1342, 1343, 1344 and SB 105, 205, 515. All refer to this subject. They are by various authors and have been referred to various committees.

Narcotics (three bills).

AB 928, by Potter (referred to Committee on Public Health), amending Health and Safety Code relating to definitions.

AB 929, by Potter (referred to Committee on Motor Vehicles), adds vehicles operated by inspectors of Division of Narcotic Enforcement to list of "authorized emergency vehicles."

AB 1180, by Middough and Potter (referred to Committee on Governmental Efficiency and Economy), relating to the cost and care of narcotic addicts.

* * *

Nursing (five bills).

AB 326, by Potter and John C. Lyons (referred to Committee on Public Health), relating to emergency nursing services.

AB 853, by Thorp (referred to Committee on Public Health), relating to nursing service by practical nurses until the termination of hostilities.

AB 1100, by Rosenthal, by request (referred to Committee on Public Health), relating to nurses and nursing schools.

AB 1833, by Clayton A. Dills (referred to Committee on Public Health), would permit chiropractic schools to issue diplomas and certificates to "graduate nurses."

SB 909, by Donnelly (referred to Committee on Business and Professions), relating to nursing schools.

* * *

Optometry (one bill).

AB 951, by Dunn (referred to Committee on Revenue and Taxation), exempts ophthalmic lenses sold by optometrists from sales tax.

Osteopathy (one bill).

AB 6, by Burkhalter (referred to Committee on Governmental Efficiency and Economy), relating to license fees of the Board of Osteopathic Examiners.

* * *

Pharmacy (nine bills).

AB 945, by Kraft, Massion, Debs and Potter (referred to Committee on Public Health), relating to temporary licenses to practice pharmacy.

AB 1335, by Kraft, Massion and Debs (referred to Committee on Public Health), regulating the sale and use of poisons.

AB 1336, by Kraft, Massion and Debs (referred to Committee on Public Health), use of alcoholic beverages while on duty constitutes a ground for revocation of certificate.

AB 1337, by Kraft, Massion and Debs (referred to Committee on Public Health), relating to time spent attending school or college of pharmacy.

AB 1338, by Kraft (referred to Committee on Public Health), repeals sections of Business and Professions Code relating to pharmacy.

AB 1455, by Kraft (referred to Committee on Public Health), relating to fees for permits to conduct pharmacies.

AB 1620, by Kraft and Potter (referred to Committee on Public Health), relating to membership of California State Board of Pharmacy.

AB 1787, by Kraft (referred to Committee on Public Health), relating to licentiates in pharmacy.

SB 452, by Engle and Mixter (passed Senate and Assembly and signed by the Governor), permits pharmacy trainees under 21 years of age to take State license examinations before being inducted into the armed services. Emergency measure.

* * *

Physical Therapy (one bill).

AB 664, by Potter (referred to Committee on Public Health), relating to the practice of physical therapy, schools of physical therapy and the registration of physical therapy technicians.

Sponsored by the California Chapter, the American Physiotherapy Association.

Premarital and Prenatal Examinations (four bills).

AB 829, by Potter (referred to Committee on Judiciary), relating to premarital examination certificates provided by other states and by the United States Army or Navy.

AB 1830, by Clayton A. Dills and Gannon (referred to Committee on Public Health), permits chiropractors to make prenatal tests for syphilis.

AB 1841, by Clayton A. Dills and Gannon (referred to Committee on Public Health), permits chiropractors to issue premarital test certificates.

SB 547, by Burns (referred to Committee on Public Health and Safety), companion bill to AB 829.

Public Health, Dept. of (two bills).

AB 686, by Lyon (referred to Committee on Civil Service and State Departments), relating to terms of board members. Places director under Civil Service laws.

AB 803, by Wollenberg and T. Fenton Knight (referred to Committee on Civil Service and State Departments), sets director's salary at $10,000 per annum.

* * *

Sales Tax (four bills).

AB 11, by Doyle and others (referred to Committee on Revenue and Taxation), exempts medicines dispensed by a registered pharmacist in accordance with the prescription of a medical practitioner.

AB 44, by Massion and others (referred to Committee on Revenue and Taxation), exempts medicines and drugs.

AB 80, by Rosenthal, Bennett and Kilpatrick (referred to Committee on Revenue and Taxation), exempts medicines dispensed by a registered pharmacist in accordance with the prescription of a medical practitioner.

AB 129, by Niehouse and Kraft (referred to Committee on Revenue and Taxation), exempts medicines and drugs.

* * *

State Guard (three bills).

Three bills have been introduced which rewrite the State Guard Act. These are AB 61, by Charles W. Lyon, and SB 1070 and 1071, by Tenney.

* * *

Veterinary Medicine (three bills).

AB 233, by Stream, Lowrey and Burns (referred to Committee on Universities and Colleges), appropriating $500,000 for establishing, equipping and maintaining a College of Veterinary Medicine as a unit of the University of California.

AB 696, by Dilworth (referred to Committee on Agriculture), relating to emergency veterinarians.

AB 1602, by Stream and Burns (referred to Committee on Universities and Colleges), relating to a College of Veterinary Medicine in the University of California.

* * *

Vital Statistics (one bill).

AB 1782, by Robertson (referred to Committee on Judiciary), establishing a uniform vital statistics act.

Workmen's Compensation (seven bills).

AB 292, by Gaffney, Berry, Haggerty, George D. Collins, John C. Lyons and Dunn (referred to Committee on Finance and Insurance), relating to percentage contracts and rebates for medical or surgical care or hospitalization.

AB 418, by Rosenthal (referred to Committee on Finance and Insurance), relating to workmen's compensation, including compensation for hernia, heart trouble and pneumonia.

AB 506, by O'Day (referred to Committee on Finance and Insurance), relating to benefits.

AB 1658, by Dickey (referred to Committee on Finance and Insurance), relating to pneumonoconiosis and silicosis.

SB 408, by Tenney (referred to Committee on Financial Institutions), relating to hernia, pneumonia and heart trouble.

SB 788, by Mixter (referred to Committee on Labor), relating to sums paid for medical, surgical and hospital treatment.

SB 792, by Mixter (referred to Committee on Labor), relating to injuries.

* * *

Miscellaneous (twenty-three bills).

AB 230, by Kilpatrick (referred to Committee on Public Health), authorizing payment of doctor's fees for doctor's food certificates by a city, city and county or county.

AB 515, by Carlson and Carey (referred to Committee on Universities and Colleges), appropriating $87,000 to establish and maintain a School of Public Health in the University of California.

AB 916, by John B. Knight (referred to Committee on Public Health), relating to liability for communicable disease care.

AB 946, by Gaffney, George D. Collins, Miller and Haggerty (referred to Committee on Civil Service and State Departments), an act relating to full-time civil service employees of this State and of any local governmental agency thereof, and restricting the activities of such persons with regard to the practice of any profession or business requiring a license issued under any statute of this State.

AB 1077, by King, Thompson, Crichton and Robertson (referred to Committee on Education), relating to the establishment and maintenance of student health services at State colleges.

AB 1268, by Desmond (referred to Committee on Ways and Means), relating to State aid to cities and counties for the treatment of persons suffering from tuberculosis.

AB 1287, by McMillan and Beck (referred to Committee on Education), relating to supervision of the health of pupils in the public schools.

AB 1553, by Call (referred to Committee on Public Health), medical inspection of food handlers.

AB 1628, by Dickey (referred to Committee on Judiciary), relating to fees and expenses of witnesses under Business and Professions Code.

AB 1659, by Massion (referred to Committee on Public Health), relating to licensing of sellers of prophylactics.

AB 1729, by Debs (referred to Committee on Judiciary), relating to physician examining person accused of intoxication.

AB 1917, by Johnson (referred to Committee on Judiciary), relating to review of decisions of administrative boards.

AB 1920, 1921, 1922, by Johnson (referred to Committee on Judiciary), relating to survival of personal injury actions.

AB 1927, by Johnson (referred to Committee on Judiciary), relating to actions for wrongful injury and death.

SB 145, by Mixter (referred to Committee on Finance), making an appropriation to the California Polytechnic School for the cultivation of herbs.

SB 282, by Tenney (referred to Committee on Transportation), relating to ambulances. Companion bill to AB 513.

SB 374, by Salsman (referred to Committee on Public Health and Safety), relating to contracts for local health administration.

SB 548, by Hatfield, by request (referred to Committee on Education), relating to medical and hospital service for pupils of the public schools.

SB 609, by Hatfield (referred to Committee on Public Health and Safety), relating to the expenditure of funds of tuberculosis wards and hospitals.

SB 1051, by Ward (referred to Committee on Public Health and Safety), making an appropriation for the education of the public concerning cancer and for the control thereof.

SJR 12, by Biggar, Gordon, Slater, and Carter, memorializing the President of the United States, the members of Congress from California and the Surgeon Generals of the United States Army and Navy, to institute investigations concerning the advantages that would accrue to the patients, if one or more military hospitals of convalescent or other nature were erected in mineral springs areas located in California. Passed by both the Senate and the Assembly.

California's Mineral Springs Resources as Available Sites for Military Hospitals

By unanimous vote of the California State Senate and Assembly, a joint resolution was adopted without debate by both houses, in the form of a memorial to the Federal Authorities urging consideration of one or more mineral spring areas located in California, as possible sites for military hospitals.

In the Senate, the joint resolution was sponsored by Senators George M. Biggar of Covelo, Frank L. Gordon of Suisun, Herbert W. Slater of Santa Rosa and Oliver J. Carter of Redding.

In the Assembly, Assemblyman Ernest C. Crowley of Fairfield was the sponsor.

Copy of the resolution follows:*

(COPY)

Senate Joint Resolution No. 12

INTRODUCED BY SENATORS BIGGAR, GORDON, SLATER, AND CARTER

January 28, 1943

WITHOUT REFERENCE TO COMMITTEE

Senate Joint Resolution No. 12—Relative to memorializing the President of the United States, the members of Congress from California and the Surgeon Generals of United States Army and Navy, to institute investigations concerning the advantages that would accrue to the patients, if one or more military hospitals of convalescent or other nature were erected in mineral spring areas located in California; with special reference to the treatment of invalid soldiers and sailors suffering from shock or nervous or other disorders and for whom mineral spring and spa procedures offer special advantages in recovery of health and rehabilitation for useful life.

WHEREAS, California possesses more than 400 mineral springs, the healing values of some of which have proven through many years of use and trial; and

WHEREAS, In European countries, and in the United States at Saratoga Hot Springs in New York and at Hot Springs National Park in Arkansas, mineral spring or so-called spa treatment has been abundantly tested and shown to be of decided worth in restoring to health and useful living, thousands of persons who were sufferers from certain nervous and chronic diseases; and

WHEREAS, World War II has already brought its toll of various injuries and diseases to many American soldiers and sailors; and

WHEREAS, Many of these invalided soldiers and sailors are now being and in the future will be brought back to our Country in order to promote their better convalescence and recovery; and

WHEREAS, Soldiers and sailors suffering from shock and other nervous disorders and chronic diseases would probably have their convalescence and recovery expedited, with more certain restoration to health and return to

* For editorial comment, see page 105.

useful military or civilian activities, if proper mineral spring treatment was available; and

WHEREAS, The mineral springs of California, in connection with beneficent climate and surroundings, offer exceptional opportunities for the placement of hospital structures, equipped with facilities for proper physiotherapeutic apparatus, pools, mud and thermal baths, and regimens of supervision; and

WHEREAS, The invalided soldiers and sailors whom such methods of treatment could especially benefit should not have these facilities denied to them; therefore, be it

Resolved by the Senate and Assembly of the State of California, jointly, That the President and the Congress of the United States and the Surgeon Generals of the United States Army and United States Navy be memorialized to institute measures that would make for acquirement of one or more mineral spring areas located in the State of California, on which appropriate spa structures with equipment and surroundings could be brought into being by the Government at an early date; in order to promote through such measures the more efficient care of a large number of invalided soldiers and sailors, and to the end that thereby their convalescence, health and rehabilitation would be more certainly promoted and their return to useful military or civilian life more definitely assured; and be it further

Resolved, That a copy of this resolution be sent to the President and Vice-President of the United States, and to the Surgeon Generals of the United States Army and United States Navy, and to the Speaker of the House of Representatives of the Congress of the United States, and to each Senator and member of the House of Representatives from California in the Congress of the United States, and that the Senators and Representatives from California are hereby respectfully requested to urge such action.

COMMITTEE ON MEDICAL ECONOMICS

New Order Governing Wages Paid and Hours Worked In California by Women and Minors

With Special Relation to Employees in Professional Offices

After holding public hearings and protracted discussions the Industrial Welfare Commission of the State of California has adopted a new wage and hour order covering "professional, technical, clerical and similar occupations." This order applies to all female and minor employees in the offices or laboratories of physicians.

Every doctor should acquaint himself with the basic provisions of this order and should immediately adjust any conditions in his own office which do not comply with the minimum provisions of the order. Failure to do so will leave the doctor liable for possible prosecution by the Industrial Welfare Commission, involving a $50 minimum fine and a 30-days' minimum jail sentence.

In connection with the provisions of the new wage and hour order, the basic provisions of the California Industrial Welfare Law should be borne in mind. In brief, these provisions are:

No female or minor employee shall be allowed to work for more than eight hours in one day, nor more than 48 hours in one week, nor more than six days in one week, nor before the hour of 6 a.m. nor after the hour of 10 p.m.

Issuance of the new wage and hour order means that specific provisions have been made for female and minor employees in professional offices, among others, in conformity with the basic provisions of the State law. These provisions as they relate to doctors' offices may be summarized as follows:

Definitions: (1) "Employee" means any woman or minor engaged or permitted to work, including students in technical, vocational or other schools who perform services for the public for which a fee is charged by the school. (Ed.—For instance, students in medical secretarial training schools who work in physicians' offices as a part of their training and who are paid any salary or for whom the physician pays any fee to the school.)

(2) "Hours employed" includes all time during which an employee is required to be on the employer's premises ready to work, or to be on duty, or to be present at a prescribed work place . . . whether or not required to do so.

(3) "Learner" is an employee who has not yet completed 480 hours of employment in the particular field of work, whether that experience has been gained in the office in which the learner is then employed or in a similar office elsewhere.

Maximum Hours: These regulations are in conformity with the basic law. They provide that no female or minor employee shall work more than 8 hours in one day, nor more than 48 hours in one week, nor more than 6 days in one week, nor before the hour of 6 a.m., nor after the hour of 10 p.m.

Minimum Wages: The new order prescribes a minimum wage of $18 a week (or $78 a month) for a 40-hour work week. Hours worked in excess of 40 hours weekly shall be compensated at a rate of not less than 45 cents an hour. For a work week of less than 40 hours, the minimum wage shall be at the rate of not less than 50 cents an hour, but not more than $18 a week, the basic wage. The table below shows the minimum wages payable for work weeks of varying lengths:

Hours per week	*Minimum weekly wage*	*Minimum monthly wage*
20	$10.00	$43.33
22	11.00	47.67
24	12.00	52.00
26	13.00	56.33
28	14.00	60.67
30	15.00	65.00
32	16.00	69.33
34	17.00	73.67
36 to 39	18.00	78.00
40	18.00	78.00
41	18.45	79.95
42	18.90	81.90
43	19.35	83.85
44	19.80	85.80
45	20.25	87.75
46	20.70	89.70
47	21.15	91.65
48	21.60	93.60

Above 48—employment is prohibited under Industrial Welfare Commission Order No. 4 N.S. (except in an emergency; a female over 18 can work 54 hours. If emergency work beyond 48 hours a week is done, the minimum pay must be the rate for 48 hours plus 75 cents an hour additional for all time up to 54 hours.)

Laundry, Uniforms, Etc.: No deduction is to be made from wages for the purchase or laundering of uniforms; the employee may not be required to purchase or launder uniforms at his or her own expense as a condition of employment.

Straight Employment: No employee may be required to work more than 5 hours straight unless the period is broken up with a meal period of not less than 30 minutes, during which period the employee shall not be liable for the performance of any duties.

Records: Each employer shall keep a record on each employee, to show the following items: name in full; home address; Social Security number; date of birth, if under 18 years of age; occupation; established day of rest; "learners" shall be designated with the letter "L," male minors under 18 years of age with the letter "M" and female minors under the age of 18 years with the letter "F"; hours employed, showing starting and quitting time for each day worked; total wages paid and total hours worked in each payroll period. Hours employed and wages paid for each period shall appear on the same record. All records must be kept for at least one year and must be kept available for inspection by duly authorized representatives of the Industrial Welfare Commission.

A survey made by the California Medical Association in August, 1942, indicated that the maximum hour and minimum wage provisions of the new Industrial Welfare

Commission order are already being lived up to or exceeded by the large majority of physicians throughout California. However, changed conditions since last August may have brought some professional offices out of line with these provisions; also, there are some physicians' offices where the basic and specific provisions of the law have not been observed in the past. It is incumbent on all physicians to follow these wage and hour provisions to the letter in order to avoid difficulties with the Industrial Welfare Commission.

ASK YOURSELF THESE QUESTIONS:

(1) Are the employees in my office working longer than 8 hours in one day, or more than 48 hours in one week?

(2) Am I paying the minimum wages of the new order? (There is no ceiling on wages in this order, merely a minimum.)

(3) Am I supplying uniforms and paying for their laundering?

(4) Are my employees required to work more than 5 hours straight without a 30-minute meal period, free from all work?

Your answers to these questions will indicate whether or not you are complying with the law. If you want further information on any specific point in the law or in the new wage-and-hour order, write to the C.M.A. office, 450 Sutter, San Francisco.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Nurses Urge Hospital Pay Increases Immediately

Hope that California hospitals will put into immediate effect pay increases long sought by the nursing profession and now authorized by the War Labor Board was expressed today by the California State Nurses' Association. Such action is vital to the public health, the nursing profession emphasized.

"The salary standards for which members of the Association of California Hospitals have sought authority are actually very low, starting at only $140 a month, without maintenance, for a graduate nurse," declared Miss Shirley C. Titus, executive secretary of the California State Nurses' Association.

"In many cases this represents only a 3 per cent increase over the salaries of past years, and is substantially below the 15 per cent pay increase recognized in the 'little steel' formula as meeting the increased cost of living.

"It is too early to state whether the hospital staff nurses of California, considerably disturbed over the long delay in adjustments of their traditionally low salaries, will consider that the $140 minimum is adequate to cover their rising costs of living, or whether this sum will be sufficient to attract new nurses to fill the profession's depleted ranks.

"It should be pointed out that the salary standards, starting at $140, were approved by organized nursing many months ago, before living costs reached their present peak, and that the nursing profession's views on salary standards have subsequently changed.

"However, if the $140 minimum pay is immediately made effective in all hospitals of California, it will serve to standardize the pay of the profession on a State-wide basis for the first time and will be at least a start toward eliminating the grave inequalities which exist in some sections of the State.

"Adequate pay for nurses is a vital public health measure since it would serve to attract new nurses to the profession and would help keep the present ranks of nurses from further reduction through competition from higher-paying occupations. Stabilization of nursing staffs for the protection of civilians is urgent in view of the hundreds of nurses who are going to war.

"The main questions before us now are whether adjustments will be adequate, whether they will be immediate and whether they will apply to all hospitals of the State."—California State Nurses' Association: 609 Sutter Street, San Francisco; 1052 West 6th Street, Los Angeles.

Nurses Swamped by Demands from Army, Navy and Civilians

Place of the nurse in today's war world is something that even the nurse herself doesn't know. Torn between military and civilian demands, the women in white are spreading themselves thin in an effort to be all things to all people. . . .

Miss Shirley Titus is executive secretary both for the California Nursing Council for War Service and the California State Nurses' Association, and she, too, is in a quandary. On the one hand are needs of the military for more nurses at once for service at the front lines. On the other hand are vital needs of hospitals here in the target area.

Staffs Reduced

"The Army and the Civilian Defense Council will just have to get together," said Miss Titus, pinchhitting today for Major Stimson. "Hospitals have never been so full. People have enough money now to pay for hospital and surgical care, and it seems to me everybody in the world is having a baby. Hospitals with a normal staff of 150 nurses are operating with 75." . . .

Hospitals are finally realizing that they must raise nurses' salaries in order to attract competent women, Miss Titus said. Only yesterday did the Association of California Hospitals announce that 90 per cent of its membership is prepared to meet the schedule of minimum salaries and personnel practices for institutional nurses, set up in October by the California State Nurses' Association.

This schedule calls for a $140 minimum entrance salary without maintenance, and increase in pay of general staff nurses at $2.50 a month up to $155 a month after completion of 36 months' service. Under maintenance, it is stipulated that the nurse shall not be required to take more than one meal a day in the hospital dining room, and not more than $10 shall be deducted from her pay check for meals.

Vacation With Pay

Under personnel practices, the nurse should have two weeks' annual vacation with pay, and 14 days a year sick leave with pay after the first year. Under time schedule, she should have a whole day off each week, recognition of six holidays a year, or a day off in lieu thereof. Other practices have been included in the schedule to give the nurse an "even break" with women in other employment.

Nurses' Aides are doing "a wonderful work—I just can't say too much in praise of them," Miss Titus reports. "I don't know what we'd do without them. They are efficient and faithful—the best help you can imagine." . . .—San Francisco *News*, December 18.

War Nursing

On the Military Front

Approximately 20,000 registered nurses are serving

with our troops in camps over here and abroad. At the same time a substantial reservoir of nurses is being built up by the American Red Cross Nursing Service. It will provide the thousands more the Army and Navy will require as their man-power approaches the ten-million mark.

Two thousand two hundred sixty-two (2,262) young unmarried nurses enrolled in the First Reserve of the ARCNS in October, a gain of 144 over September enrollments. (A recent regulation of the War Department makes married nurses, under 40 and having no uncared-for dependents, eligible for military service).

Overseas

The number of American nurses serving beyond our coasts is a military secret. It grows as our armed strength in the four corners of the world increases. Reports have filtered through of their presence in: Africa, Alaska, Australia, China, England, Greenland, Hawaii, Iceland, India, Ireland, Jamaica, New Caledonia, Newfoundland, New Guinea, New Zealand, Panama, Puerto Rico, and Trinidad.

In Continental U.S.A.

Army and Navy nurses are serving in more than 300 hospitals dotting the length and breadth of the Union. They are stationed at forts, camps, barracks and navy yards. They are also in ordnance departments, quartermasters' depots and disciplinary barracks. They are stationed at proving grounds, gunnery schools, air bases and flying schools.

Fifteen hundred (1,500) Army nurses have also been assigned to air evacuation units organized for the aerial transportation of sick and wounded from theatres of war. Assigned to station hospitals at Army air fields, these nurses are given flying experience in transport planes which accommodate forty patients and are equipped with facilities for surgery, blood transfusions and other emergent treatment.

On the Civilian Front

Nursing "as usual" is out. Adjustments are the order of the day.

Essential services—the care of the sick in hospitals and home, prevention of disease and of disabling conditions, and education for healthful living—are carried forward. But the services of nurses on hospital and public health nursing staffs are supplemented to a larger extent than ever before by nurses serving on a part time basis; by student nurses; by volunteer nurse's aides; and by paid auxiliary workers.

Heavier loads are carried by nurses all along the civilian front.

Reasons:

More patients seek care in hospitals each year.

Doctors are scarcer. Thousands are in military service.

Nursing ranks are thinning as more and more respond to the call to the colors.

High turn-over on nursing staffs calls for more carefully planned staff-orientation programs.

The greater use of auxiliary workers in the care of the sick calls for more constant and careful supervision on the part of registered nurses.

War pressures resulting in industrial speed-ups, stricter food and fuel rationing, inadequate home care of children, mental and nervous strains, all call for sharp expansion in public health nursing programs.

Dislocated populations, the boom-towns around industrial plants and military camps and the Japanese-Americans evacuated from target areas to relocation centers in the West and Middle-west, call for more nursing services than can readily be provided by local nurses.

One-time spare time is filled with such extra activities as teaching classes in home nursing or first aid; teaching refresher courses to graduate nurses; staffing Red Cross casualty centers; developing civilian defense nursing corps; and participating in the programs of local or state nursing councils for war service which have been organized in every state.

Closely associated with the sub-committee and the Council is:

The United States Public Health Service

Administratively responsible, through its States Relations Division, for the $3,500,000 appropriated by Congress for nursing education for the school year, 1942-'43.

Women In War

Marian Randall, head of the Nation's Civilian Defense nurses for O.C.D. for the past year, finds California's women in white are "doing a magnificent job."

The distinguished public health nurse, whose official title is Chief Nurse, Medical Division, Office of Civilian Defense, was in San Francisco during the week of January 25th, from Washington, D. C., looking over the preparations made for nursing care in case of enemy attack. This was her first trip of inspection to the West Coast.

"Working for something you pray will not happen is a hard thing to do," commented Miss Randall. "However, I cannot emphasize too strongly the importance of the participation of every available nurse in civilian defense. Despite the thinning ranks of the nurses, brought about by the demands of the armed services, and increased civilian needs under the difficult conditions of wartime, the California nursing profession is doing an admirable job."

Conferring with Miss Randall this week were representatives of the State's Emergency Medical Service which functions under the State Council of Defense. Nurses of the Emergency Medical Service are ready in time of disaster to serve in hospitals, to man casualty stations, base hospitals and take care of patients in their homes, should hospital space be unavailable.

According to Miss Ruth McCullagh, nurse deputy for California, more than 6,000 nurses are signed up with the State's Emergency Medical Service.

Units are organized in counties and cities throughout the State with a nurse deputy working closely with the medical chief in each locality. The nurse deputy keeps a file of all nurses who will respond for duty either in their own communities or who will be able to go to other districts where they may be needed for disaster service.

"Even if the bombs never fall — and we hope they never do —" says Miss Randall, "the nursing profession is benefiting greatly from civilian defense activities. Nurses are brushing up on their first aid courses. They are being given opportunity to learn the newest scientific developments, which the war is hastening, such as administration of blood plasma, and the newest treatments for burns and for accident cases.

"The use of our nurses in the recent tragic Boston fire is an example of how valuable our new training has become. Then, too, we are learning to know each other better and how to work together as never before."

Conferences were held by Miss Randall with Mrs. Mildred Byers, nurse consultant for the Ninth Region of O.C.D.; Miss McCullagh of State Emergency Medical Service; Mrs. Christie Thompson, nurse deputy for Nevada; Mrs. Minnie Benson, nurse deputy for Arizona, and nurse deputies for a number of key California counties and cities.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Brochure on Nutrition: By San Bernardino County Medical Society

The Nutrition Committees of the San Bernardino County Defense Council and the San Bernardino County Medical Society recently brought off the press a neat 3 by 5 brochure of 6 pages, text of which is presented below:

Lesson 1.

STAGES OF HEALTH

1st Stage—Buoyant health, with energy and zest for living.

2nd Stage—The so-called normal state. Able to earn living.

3rd Stage—Sick in bed.

Comments: Most of us find ourselves in the second stage of health, one step above sickness in bed, one step below buoyant health—all determined largely by the wisdom used in our food selections.

* * *

Lesson 2.

VITAMINS A, B, AND C

Vitamin A—Supplied mostly by the green and yellow vegetables and fruit, and by butter and liver.

Vitamin B Complex—This includes B_1, B_2, and niacin. Supplied by all natural foods. Important sources are ham (not bacon), lean pork, other lean meats, milk, eggs, whole grain foods, legumes.

Vitamin C—Most plentiful in oranges, grapefruit and tomatoes.

Note: For adequate reserve supply in your tissues, plan your meals each day to include foods that supply these vitamins.

* * *

Lesson 3.

PROTEINS—ANIMAL AND VEGETABLE

The Proteins are the *building blocks* of the body. Those proteins of animal origin—from milk, cheese, eggs and meat—are more complete and contain better building materials than the proteins derived from the grains, vegetables and fruits.

Therefore each adult and child needs *every day* the following foods: milk*, buttermilk, or cheese; and meat, fish, or fowl; and one egg, to supply the protein requirements.

* One pint for the adult; one quart for the child, one quart or more for the adolescent.

* * *

Lesson 4.

CALCIUM AND ITS REQUIREMENTS

Calcium is a mineral, and like iron must be considered in planning for a good diet. It is needed for the nerves, the heart, intestines, and other soft tissues, as well as for the bones and teeth.

If milk, cheese, or buttermilk is not taken daily, a calcium deficiency may result.

* * *

Lesson 5.

UNWHOLESOME FOODS—*Classification*

Foods made from sugar:

Candy, carbonated beverages,

Synthetic syrups.

Foods made from "refined" unenriched white flour: Unenriched bread, waffles, hot cakes, doughnuts, cookies, pies, cake. NOTE: These foods are considered unwholesome because vitamins, etc., were removed when the wheat and the sugar plants went through the refining processes.

Begin *now* using enriched or 100 per cent whole wheat bread, and for dessert demand fruit*, nature's packages of vitamins and energy.

*May use dried, canned, or fresh fruits. They give *energy* plus vitamins, minerals and sugars.

* * *

Lesson 6.

VALUABLE FOODS—*Inexpensive*

Potatoes—White or Yellow.

Dried Beans and Peas. Peanut Butter.

100 per cent *Whole Wheat* Bread or *Enriched* Bread.

Whole Grain or *Enriched* Cereals.

Wheat Germ Middlings (Also called "scalp of the sizings"). This is a cereal for cooking, and is richer in vitamins than the whole grain, but not as rich as pure wheat germ.

Wheat Germ. At breakfast and lunch, or dinner, add one tablespoonful of wheat germ to milk or other food.

Buttermilk, Cheese, Whole Milk.

Cheaper Cuts of Meats, Lean pork, *Liver* of beef and lamb.

Fruit for dessert as a routine.

102,500 Die in Accidents in U. S. in '41

Chicago.—Accidents throughout the United States in 1941 killed 102,500 persons and permanently disabled another 350,000, the National Safety Council's statistical year-book revealed.

This compares with total United States casualties in World War I of 364,800.

The accident toll meant the loss of 460,000,000 man-days of work or the equivalent of 1,500,000 workers, the Council reported. Cost to the nation was estimated at $4,000,000,000. The council's safety engineers listed 97 per cent of the accidents as preventable.

Traffic accidents led other causes with a list of 40,000 dead, 1,450,000 injured and a cost of $1,900,000,000. Accidents in the home ranked next with 31,500 killed and 4,650,000 injured and a cost of $600,000,000. Other public accidents of all kinds took a toll of an additional 15,000 dead and 1,800,000 injured.

On-the-job accidents killed 18,000 workers, injured 1,600,000 and cost the country $850,000,000.

William A. Irvin, of the United States Steel Corporation, chairman of the War Production Fund to Conserve Manpower, pointed out that the staggering losses suffered by the United States through accidents are a direct threat to victory.

"We Americans have been killing ourselves at a record-breaking rate," Irvin said. "Since the beginning of the war, the Nazis have killed 43,300 English civilians in mass air raids. We more than doubled that figure in accidents alone. Accidents must be reduced for victory."

Work Grows for Physicians, Survey Shows

The patient the doctor left behind him—

This is the category into which a large portion of the American public falls today — at least on the Pacific Coast, has been again emphasized by an American Red Cross survey.

And as a result of the survey, made by Dr. Milton Rose, Pacific Area director of health service, and Miss Edith Olson, assistant director of the Red Cross Nursing Service, Red Cross nursing services have been arranged, or are being considered, for five Coast cities.

In comparison with these cities, the figures released by Miss Olson show, San Francisco, in spite of having lost more than one-third of its doctors—is a heaven of medical attention, with its visiting nurses and city health department. . . .

This followed disclosure by Dr. Harold Fletcher of the Assignment and Procurement Service here, that 568 San Francisco doctors already have been commissioned. This is out of a total of 1,745 doctors in the city, about 1,500 of whom were practicing, Dr. Chester Cooley, Secretary of the San Francisco County Medical Society, said. (Some were research physicians at the medical schools, some on staffs of military hospitals.)

This leaves about 1,000 doctors to care for the city's expanded population—from 634,535 in 1940 to 728,235 in the air raid warden census.

Said Dr. Cooley: "The doctors have been doubling up, of course. Then the County Medical Society has put in a direct wire service for any one to call, day or night. We have several doctors on call.

"Some hospitals have allowed their resident physicians to take calls in the neighborhood when people can't get doctors.

"The load has increased tremendously. Many doctors are working together so one can cover for two, giving the other a night's sleep occasionally.

Dr. Geiger summed it up like this: "No one is being neglected in San Francisco that I know of. But doctors are caring for more patients, and those in certain specialties have to do the work of other specialties.

"As a whole the citizenry is being magnificently handled by the medical profession. And so far, no epidemics are in sight, except an increase in cases of cerebro meningitis which we seem able to take care of. It's a strain, and I don't know how much more it can take. We may be able to lose a few more doctors, but darn few! And certainly no more nurses!"

Another picture of the medical status quo came in a statement today by Dr. Karl L. Schaupp of San Francisco, president-elect of the California Medical Association. California citizens are still receiving a high standard of medical care and will continue to receive it in spite of military demands for doctors, he declared.

The explanation by Dr. Schaupp, also Ninth Corps Area chairman of Procurement and Assignment Service, was backed by Dr. Fletcher, physicians state chairman of the service.

Dr. Schaupp emphasized, "So many rumors have been heard about the so-called doctor shortage it is time the citizens of California learned the facts.

"A survey just completed by the Association shows that with very few exceptions the communities of this State have enough doctors still in practice to give civilian population adequate medical care. There are some cities and some rural areas where additional doctors are needed, but the relocation of 20 doctors, at the outside, would bring the medical population up to standard in these cases. We expect to handle this relocation work in the next few months."

The survey, he said, shows only six of the 58 counties with any doctor problem and only four that really need more doctors.

"Judged by nation-wide standards," he pointed out, "California is more than adequately supplied with doctors. This does not mean that peace-time standards can be maintained. We are at war and the needs of the Army and the Navy for medical officers must be met.

"Neither does it mean that the civilian population can expect luxuries in medicine, nor that the doctors can hope to practice on pre-war schedules. The doctors are accepting their increased burden without complaint, even though it means a personal sacrifice."

Dr. Fletcher, in confirming these statements, declared "great progress has already been made" in meeting shortages near defense plants where population has increased, and promised that "it looks as though the rest of them will be taken care of . . . in the near future."

Underlining the assurance, Dr. Schaupp said, "California not only has enough doctors, but it is one of five states in the country still enjoying the luxury of a medical surplus."

Just as a final touch to the situation came the revelation at the University of California Hospital here that staff members no longer have waiters to bring them their lunch at the Faculty Club—or to clear the tables either. "Help is scarce," said F. S. Durie, hospital superintendent, "and the physicians know it is needed worse in other places than the dining room."—San Francisco *News*, January 22.

Women in Industry

Dr. H. Close Hesseltine, chairman of the obstetrics and gynecology committee of the American Medical Association, in giving his committee report to the fifth annual Congress on Industrial Health, advocates regular plant physicians, industrial hygiene services and control of unhealthful exposure. In addition, his committee recommends that:

1. Mothers should work only on day and afternoon shifts, since women generally work at home in addition to their factory jobs.

2. Maximum weight lift for women should not exceed 35 pounds—lower for older or pregnant women.

3. Women should wear slacks, comfortable low shoes and avoid dangling sleeves on blouses.

4. Women should be employed 36 to 48 hours per week, depending on the work and the individual.

5. Proper rest rooms should be provided for women, with couches for them to recline.

6. Each plant should have four women or matrons familiar with supervision of women employees.

7. Strain and too long periods of sitting or standing should be avoided.

8. Pregnant women should be kept from contact with injurious substances, including lead, mercury, arsenic, phosphorus and benzol.

9. Adequate rest periods should be provided, particularly for pregnant women.

10. Pregnant women should not be employed after six months before birth of the child, or after the 34th week of pregnancy. She should not return to work until six weeks or more after birth.

11. Adequate care should be provided for children of mothers in industry.

American Public Health Association Urges Ban on Prostitution

Suppression of prostitution is essential for control of venereal disease, two medical and health authorities declared at the opening meeting of the American Public Health Association, held on November 12, in St. Louis.

"Some persons in charge of important medical and public health activities of official agencies, civilian as well as military, are not yet convinced of the desirability of suppression of prostitution as an element of a venereal disease control program," Dr. Theodore Rosenthal of the New York City Health Department charged.

"Proper information on the value of this phase of venereal disease control is essential."

The information, in the shape of a report showing how venereal disease rates dropped among soldiers at Fort Bliss, Tex., when prostitution in the vicinity was suppressed, was furnished by Dr. Bascom Johnson, Jr., U. S. Public Health Service officer assigned to the El Paso, Tex., City-County Health Unit.

Fort Bliss, an expanding military cantonment with many thousands of troops, he explained, is located within a short distance of El Paso, which is within easy walking distance of Juarez, Mexican border city just across the Rio Grande.

"When this study was started," he stated, "commercial prostitution was flourishing both in El Paso and in Juarez. There were nine well-known houses of prostitution in El Paso under police surveillance, and in some respects, almost under police protection. The women in these houses were being examined once a week in the city police department by local health department personnel.

High Rate Disclosed

"During this period almost 75 per cent of the Army's infections was found to be coming from houses of prostitution. Fifty-seven per cent were apparently contracted in El Paso, the remaining 43 per cent was fairly evenly divided between Juarez, Mexico, and communities outside the El Paso-Juarez area. However, of 155 cases contracted in El Paso fully 84 per cent was said to be acquired in the nine houses of prostitution where the women were being examined once a week.

"There followed a period when El Paso's houses were closed but flagrant prostitution conditions remained readily accessible in Juarez, Mexico. The percentage of venereal infections coming from El Paso decreased about 25 per cent but the percentage coming from Juarez increased almost an equal amount. It was impossible to demonstrate any decrease in Army venereal rate which could be attributed to the improved conditions in El Paso.

"After war was declared, the International bridge to Juarez was closed to American soldiers on Dec. 8, 1941. It remained closed for 82 days. During this period the Army venereal rate dropped to 36. On Feb. 28, 1942, due to diplomatic pressure, the bridge was reopened to soldier traffic and the venereal rate went up again to 60. On June 19, 1942, a policy of repression of prostitution was started in Juarez. Since then the Army venereal rate has gradually declined again. The rate for July, 1942, reached an all time low of 28 cases per 1,000 men per annum."

Old Argument Refuted

Contrary to one of the standard arguments against suppression of prostitution, closure of the houses did not, so far as Dr. Johnson could find, cause any widespread dissemination of these women throughout the community. According to the statements of the prostitutes themselves, the vast majority leave town as soon as the "heat is turned on."

As the prostitutes are eliminated, the "non-prostitute pickup" or "chippie" becomes more important as a source of venereal infection, Dr. Johnson stated. An attempt is now being made in El Paso to set up a redirection program for these borderline prostitutes. Sociological studies are badly needed, Dr. Johnson declared, to help health and social workers solve the borderline prostitute problem.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

State and County Medical Societies: Some Functions and Responsibilities

The Ohio State Medical Association, in the January issue of its *Journal*, presented an outline of work and obligations facing organized medicine. Excerpts from the excellent presentation follow:

More and more frequently the question is being asked: "What is the medical profession doing to help meet the community health situation created by increased demands for medical services and decreased numbers of civilian physicians?" The obvious answer is, of course, that individual physicians are working long, hard hours and will continue as individuals to do all that is humanly possible to meet the medical needs of the people generally.

But it is to the medical profession as a group that the questions are directed and the answer must be given in terms of organized effort. In other words, the leadership must be furnished by the State Medical Association and its county medical societies, working coöperatively with other organizations representing allied professions.

The medical profession has met and will continue to meet the challenge of the government with respect to providing its share of medical officers for the armed forces. The record speaks for itself and is one of which the medical profession can be proud.

At the same time, the medical profession is confronted with a challenge from the civilian population. The people have willingly given up several thousand of their physicians for military service. They are counting on those members of the profession who are ineligible for one reason or another for military service to maintain necessary medical and health services.

The present medical and health situation in general is one which should not cause anxiety. There is sufficient medical manpower in the State to meet immediate or future problems. True, there is a question of more equitable distribution but this can and will be worked out by the State Association and the Procurement and Assignment Committee. A few areas are undermanned medically speaking but these conditions are rapidly being remedied—or will be in the near future. Facts do not substantiate certain exaggerated and alarming statements which have been made about conditions by those who have not been in possession of factual information.

Nevertheless the medical profession should not strike a smug attitude as there is work to be done and vital situations to be corrected. Each county medical society must do its part locally toward upholding the medical profession's responsibility in meeting civilian needs. Following are some suggested methods, some of which can be put into effect by each physician as an individual and some which will require organized effort on the part of the county medical society. They should be discussed at county society meetings.

Alert and Proper Organization Essential

Regular Meetings.—Matters relating to the war effort and health questions arising from the war should be discussed fully and freely at county medical society meetings. Unless the societies meet regularly this cannot be done and only a portion of the things which should be done can be accomplished. Every society should make every effort to maintain a regular meeting schedule—special meetings if necessary.

Active Officers.—No society can be on its toes unless it has active officers and committees. At this particular time the responsibility of officers is great. Each society has a right to insist that its duly elected leaders give the profession leadership in the many efforts which are necessary to properly meet wartime problems.

Committee on Medical Preparedness.—Each society has, or should have, an alert and active Committee on Medical Preparedness. Such a committee may be classified as a major unit of the county medical society at this time. It constitutes the liaison between the local medical profession and the state and national organizations dealing with war activities. It must function efficiently. It must consist of members with sound judgment and courage.

Volunteer Assistance.—Officers and committeemen should not be expected to shoulder all the responsibility and all the work. They need the help of all members. This is especially true now. Organized effort means interest and action on the part of each member.

Assuring Constant Availability of Medical Care

Emergency Cases.—In several communities already medical societies or groups of physicians have set up plans designed to guarantee constant availability of medical care for emergency cases. These have been properly publicized to tell the people of the area that the profession is aware of its obligations and to forestall situa-

tions where it might not be possible to get a doctor when one is needed.

Responsibility Shared.—In principle the mechanics of these plans are similar. Generally, the responsibility for emergency calls at night is rotated among all participating physicians so that at given intervals a certain physician is charged with accepting all emergency night calls and those where the family physician cannot be located. In larger communities, the area thus covered is zoned, with different physicians responsible for different zones.

Central Call Station.—Usually, the plans for emergency services and zoning are administered through some central point such as a hospital, city health department, or the local physicians' switchboard service. Obviously, a central call station adds to the efficiency of the plan and should be maintained if at all possible.

Staggered Office Hours.—Besides providing constantly available services for emergency, several of the plans include mutual agreements for the staggering of office hours and days off, thus assuring their respective communities that a sufficient number of physicians are always on hand in the community.

Rotating Calls.—There are some suburban or outlying areas of semiresidential nature in which there are no physicians. These are potential sources of trouble even though the metropolitan areas of which they are a part have sufficient physicians. This situation has been met in several instances through a mutual agreement among physicians of the metropolitan area. Either they have agreed to rotate days actually spent in the communities in question, or they distribute among their group all calls from those communities. In extremely rural areas, it might be possible for physicians of towns adjacent to those without physicians, to arrange for holding office hours on certain days in the latter towns, on a rotating basis. The question of charges and mileage must be considered.

Charges and Mileage.—Excessive charges for calls to outlying areas must be avoided. The physician is entitled to a reasonable fee for long trips but each should remember that these are times of emergency, not to be taken advantage of. Necessary services must be provided for all areas. This will break down if the costs are excessive. Here is where the physician can make a real contribution toward meeting problems arising from the emergency. Each county society would do well to consider immediately the problems of the outlying areas as they are potential sources of trouble.

Preventive Services.—As factors in reducing unnecessary demands for medical services and minimizing illness, preventive medical practices and health education have assumed added importance. The county medical society is the logical agency to assume leadership in fostering both. Preventive medical practices can be promoted in two ways: (1) The society as a group can actively cooperate with health officials and school authorities to further worthwhile programs of immunization and other preventive measures, or (2) the physician in private practice can tactfully recommend to his patients the various procedures he believes they should take to insure good health.

Health Education.—Education of the public in such fields as good nutrition and sound personal hygiene must be sustained at this time more than ever. Toward this end, the medical society should actively coöperate with acceptable health education and nutrition education agencies in the community. Press releases by local societies are desirable. The Bureau of Public Education of the State Medical Association is producing material of this kind and will assist local societies on request. Such releases also should advise the public how it can help in conserving the time of the physician working under emergency conditions.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Los Angeles County General Hospital Changes Method of Collections

"Persecution" method in the collection of bills from needy people who use the general hospital were attacked this week by Supervisor John Anson Ford.

The board first sliced from 147 to 25 the number of chargeable items, then Ford said that was only the beginning.

"I have learned through investigation that a small minority of the people treated at the General Hospital are paying reasonably high fees, because they honestly wish to meet their obligations," said Ford.

"About $500,000 annually is collected from patients and their relatives, toward offsetting the $4,500,000 annual operating cost of the institution.

"Unfortunately this minority group of conscientious people who pay for services are billed at prices averaging higher than it costs the charity patient in many other California counties.

"Furthermore I intend to follow through on this policy matter and if possible eliminate the present practice of hounding and persecuting unfortunate people for payment of bills, which common sense indicates they would never have contracted if they could possibly afford treatment in private institutions."—Los Angeles *Eastside Journal*, January 20.

Riverside County Medical Men Ask Hospital Power

Medical Association Responds to Board's Invitation for Suggestions by Asking to Set Up Advisory Council of Doctors

The Riverside County Medical Association responded to the invitation of the Board of Supervisors extended by letter January 18, to make suggestions for the operation of the county hospital at any time. The association, through its officers, sent the following letter to the board on Monday. The letter stated that it was in answer to the invitation of the board and then made the following recommendations:

"1. That the Medical Superintendent be given complete charge of the operation of the hospital.

"2. That a hospital committee of five physicians, one from each supervisorial district, each to be an active member of the Riverside County Medical Association, be named to serve as a directing committee of the Riverside County Hospital.

"The members of this committee shall be appointed by the Board of Supervisors from an eligible list submitted as nominees to be selected at a regular meeting of such association, when requested by the Board of Supervisors, but in any event, at least once in each calendar year.

"The principal duties of the directing committee shall be the supervision and control of admittance; and recommendations as to policies of the hospital.

"A further duty of the committee will be the advising of the Board of Supervisors as to the selection of future superintendents for the hospital and as to hospital problems generally.

"3. That there be maintained and available at the hospital at all times, and subject to examination by the members of the hospital staff and directing committee of the hospital, an active up-to-date social service history of all patients of the hospital.

"These recommendations are submitted to your board for your consideration and it is our desire that an early action be taken and that we may be notified of such action in a reasonable length of time." The letter was signed by Thomas A. Card, president, and W. K. Templeton, secretary-treasurer.

The letter was filed without comment by board members, a procedure that usually indicates that the matter will be discussed in a closed session.—Riverside *News*, January 28.

Big Gains Shown at Riverside Community Hospital

In the face of growing shortages of nurses and doctors because of the demands of the armed forces, Riverside Community Hospital had 3,541 patients, an increase of 770 patients during its first wartime year over the 1941 total of 2,771, according to reports filed with the board of directors last night.

This was almost twice the volume of patients, 1,960, admitted in 1939. . . . —Riverside *Press*, January 19.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (70)

Alameda County (3)

Purcell, Edward, *Oakland*
Thorpe, M. W., *Hayward*
Zander, Charles H., *Oakland*

Los Angeles County (49)

Alpert, Clarence D., *Los Angeles*
Anderson, Lucille Russell, *Los Angeles*
Bluechel, Theodore John, *Rolling Hills*
Brokensiek, Clifton Mack, *Bellflower*
Brophy, Truman W., III., *Los Angeles*
Chrisman, William D., *Lynwood*
Cooley, Arthur Dike, *San Pedro*
Couperus, Molleurus, *Los Angeles*
Curtis, Charles Havelock, *Los Angeles*
Daniells, Jr., Arthur G., *South Gate*
Dart, Edward E., *Los Angeles*
Dorsch, William A., *Compton*
Frankl, Julius, *Los Angeles*
Frazier, Frank P., *Bell*
Gandin, Morris M., *Los Angeles*
Gaspar, John Lambert, *Los Angeles*
Hallstone, Victor Everett, *Huntington Park*
Harvey, Andrew Magee, *Long Beach*
Hawkins, Jr., J. Lawrence, *Huntington Park*
Hoefer, Harold Francis, *Los Angeles*
Hustead, Edwin L., *Los Angeles*
Jones, Deward W., *Los Angeles*
Jones, Kenneth Paul, *San Fernando*
Kamins, Maurice Lloyd, *Los Angeles*
Keate, Wendell Snow, *Santa Monica*
Keller, Virginia Peck, *Glendale*
Kelso, Raymond A., *Los Angeles*
Keys, John A., *Manhattan Beach*
Levien, Nathaniel Irving, *Beverly Hills*
McGregor, Helen, *Huntington Park*
Mokler, Victor A., *Los Angeles*
Moore, Fred T., *Los Angeles*
Moran, Helen Christine, *South Pasadena*
Newkirk, Merlin Louis, *South Gate*
O'Flaherty, A. E., *West Los Angeles*
Palazzo, John R., *Los Angeles*
Perelson, Harold Nathan, *Huntington Park*
Peterson, John E., *Los Angeles*
Roberts, Chester Llewellyn, *Glendale*
Rubin, Henry Joel, *Los Angeles*
Schube, Purcell George, *Pasadena*
Sickafoose, Harry R., *Wilmington*
Snodgrass, Wilfred James, *Santa Monica*
Storkan, Joseph Charles, *Gardena*
Tennison, William James, *Arcadia*
Ward, Ernest Trulock, *Huntington Park*
Watkins, J. Frank, *Los Angeles*
Webster, Marion Terwilliger, *Inglewood*
Works, Royal Leone, *Los Angeles*

Orange County (2)

Page, Harlan, *Laguna Beach*
Thompson, Floyd F., *Santa Ana*

San Bernardino County (2)

Dunsmoor, R. M., *Fontana*
Sprague, Charles P., *San Bernardino*

San Diego County (4)

Ballard, M. D., *San Diego*
LeMarquis, Antionette Y., *San Diego*
Martin, Worthington Lee, *San Diego*
McCracken, Robert H., *San Diego*

San Francisco County (8)

Albrecht, Joseph J., *San Francisco*
Johanson, Raymond Richard, *San Francisco*
McClure, Joy L., *San Francisco*
Melvin, Harry A., *San Francisco*
Mohr, Jr., Selby Rudolph, *San Francisco*
Mottram, Martha Elizabeth, *San Francisco*
Movitt, Eli Rodin, *San Francisco*
Pasqualetti, Roy Antone, *San Francisco*

San Mateo County (1)

Kading, Earl C., *San Mateo*

Santa Clara County (1)

McGinty, Arthur T., *San Jose*

Transfers (2)

Van Atta, Margaret A., from Los Angeles County to San Diego County
Wood, Dorothy A., from San Francisco County to San Mateo County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Browne, George Cecil. Died at Oakland, January 20, 1943, age 65. Graduate of the College of Physicians and Surgeons of Baltimore, Maryland, 1899. Licensed in California in 1899. Doctor Browne was a member of the Alameda County Medical Association, the California Medical Association, and the American Medical Association.

✣

Giannini, Attilio H. Died at Los Angeles, February 7, 1943, age 68. Graduate of the University of California Medical School, San Francisco, 1896. Licensed in California in 1896. Doctor Giannini was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Schulze, Margaret. Died at San Francisco, February 7, 1943, age 48. Graduate of the University of California Medical School, San Francisco, 1916. Licensed in California in 1916. Doctor Schulze was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

Wise, Philip L. Died at San Jose, January 8, 1943, age 63. Graduate of the University of Southern California School of Medicine, 1905. Licensed in California in 1905. Doctor Wise was a member of the Santa Clara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

"And in the end, through the long ages of our quest for light, it will be found that truth is still mightier than the sword. Because out of all the welter of human carnage and human sorrow and human weal the one great indestructible thing that will always live on is a sound idea."—Gen. Douglas MacArthur.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

State News

The Spring meeting of the State Board was held at Chapman Park Hotel in Los Angeles, on February 12, at 10 a.m. The Executive Board met at 9 o'clock, Mrs. F. G. Lindemulder, President, in the chair. State Board members were welcomed by a committee from the Los Angeles Auxiliary. Among events planned were a special luncheon at the Hotel and a Red Cross tour in the afternoon. The Nominating Committee met in the Hotel the night before, when Mrs. Randall Madelay presided as chairman.

There were three District meetings in January: San Francisco, January 12, when four Auxiliaries participated; Santa Cruz, January 13, when three Auxiliaries were represented, and Santa Barbara, January 14, with two Auxiliaries participating. All of these meetings, well attended, were interesting, and lively discussions resulted.

County News Items

With a desire to further serve humanity, the members of the Woman's Auxiliary to the San Francisco County Medical Society held a day for their membership at the Irwin Memorial Blood Bank, 2180 Washington Street, Monday, February 1, to donate their blood for Whole Blood and Blood Plasma for use in local hospitals, and to build a reserve supply in case of enemy attack or any other disaster.

The Irwin Memorial Blood Bank operates under the direction of the County Medical Society, and, as a project, the members of the Auxiliary entirely staff the following departments: Couriers, drivers of the Blood Bank station wagon delivery service, and Canteen Corps. These volunteers work six days a week, from 8 a.m. to 6 p.m. This service has been in operation for the past year.

The Telephone Committee, under the direction of Mrs. Frank Hand, contacted the membership to make appointments and furnish all necessary information. Members were asked to give the usual pint of blood needed for adult transfusions, or a portion of a pint for infant transfusions, a unique service of the Irwin Memorial Blood Bank.

The San Francisco group holds no regular meeting in February, but preparations are under way for an especially fine program for the March meeting.

On January 8, the members of the Monterey County Auxiliary met at the home of Mrs. Rollin Reeves in Salinas, for a combined social and business session. Mrs. Walter Farr was named Chairman of the Nominating Committee.

Mrs. F. G. Lindemulder, State President, attended a joint meeting of the Monterey, Santa Cruz, and Santa Clara County Auxiliaries. Ways and means, to meet the current problems imposed by wartime conditions and the continuance of meetings during the duration, were discussed.

Monterey and San Benito County Medical Auxiliaries meet separately in their own communities, due to the gas and tire rationing.

The Humboldt County Auxiliary met at the home of Mrs. Walter Dolfini on January 14. As the dimout restrictions make it increasingly more difficult to attend evening meetings, it was decided to have alternate meetings in the afternoons instead of the usual evening meetings.

Mrs. Joseph Walsh has been appointed to contact the local U.S.O. regarding specific articles to be supplied by the Auxiliary during the current year.

On January 10, the Riverside County Medical Auxiliary met at the Riverside Community Hospital. Mrs. Wayne Templeton, President, opened the meeting with a prayer for the success of the armed forces of the United States. A list of the Riverside County Medical Society members in the Service was read.

Mrs. Ralph Smith, *Hygeia* Chairman, reported that 45 subscriptions to *Hygeia* had been ordered for distribution to schools and other public places, as a result of the recent benefit party staged by the Auxiliary.

An important matter discussed at the January meeting of the Auxiliary to the Sacramento Society for Medical Improvement was the method of raising monies for the annual contribution to the Medical Benevolent Fund. Sacramento County Auxiliary has received special recognition in the past for their generosity in contributing to this Fund.

Another project of this group is the making of layette garments for the Fairhaven Home. Used garments for babies and mothers in the Home were collected at the January meeting. Hostesses were Mrs. Dave Dozier, Mrs. Edward Babcock, Mrs. Gandolpho Prisinzano, Mrs. William S. Harding and Mrs. John Lawson.

The Alameda County regular luncheon-meeting was held at the Claremont Country Club on February 19, with Mrs. T. Floyd Bell presiding.

The third Tuesday of each month, Alameda County members take over Hospitality House and serve during the day and evening. All food is donated by members. Mrs. Rossner Graham, Hospitality House Chairman, has announced that cash contributions during January totaled forty-five dollars. This was gratefully received by those in charge, as the fund necessary to carry on this work is dependent on the voluntary contributions of members.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (January)		35,000
Rural Health Program		5,000
War Housing Projects (February 1)		
(Approximate)		35,000
Marin	5,000	
Los Angeles	7,000	
San Diego	10,000	
Vallejo	13,000	

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Our extension of the Rural Program has not been as rapid as we had hoped, although approximately 400 new families were enrolled as of January 1st. We expect to extend this program still further in the coming months.

Steps are being taken to develop a program to meet the needs of counties in Northern California, particularly to cover the employees of lumber camps, mines, etc. We hope to institute this activity beginning with the first of April, and believe that the program will be successful from all viewpoints.

The progess of converting the full coverage to the two visit deductible is approximately 50 per cent complete. According to our present rate of progress, this program should be completed in the late spring or early summer. The effects of the change are already becoming noticeable. There has been a fairly steady increase in the unit value, reaching a top of $1.50 per unit for services rendered in the month of December. The rate of $1.50 payable for December, 1942, compares very favorably with the rate of $1.10 paid per unit for the month of December, 1941.

FSA Health Insurance Plan Offered Santa Clara County Farmers

For the first time Santa Clara valley farmers will have an opportunity to subscribe to the Farm Security Administration-California Physicians' Service sponsored health insurance plan.

The program, designed especially for rural families of California, offers medical, surgical and hospital care for just a few cents a day per person, according to G. L. Taggart, head of the FSA office in San Jose.

Coöperative Plan

It is a coöperative plan whereby farm families with low cash incomes can be assured of needed medical service. The plan is available for all FSA borrowers and other farm families in the county whose annual net incomes for state income tax purposes are $2,000 or less.

Medical benefits include all medical services that may be necessary as a consequence of illness or injury and all necessary obstetrical care, in the office of a CPS professional member, in the home when necessary or in a hospital if necessary.

Covers All Ailments

All x-ray and laboratory examinations necessary in the opinion of the attending physician, or specialist services are covered by the insurance plan.

The service also includes treatment of chronic ailments that are contagious, infectious or painful and obstetrical services, Taggart emphasized.

Annual dues for the Santa Clara County Farmers' Health Association are $20 for one adult member; $40 for one adult and one child or two adults; $50 for two adults and one child, or one adult and two children, and $60 for three adults or four or more persons.

Handled Locally

All applications to join the Health Association must be filed at the local FSA office, 503 Burrell Building, San Jose, before February 15. . . .

Farmers who do not have the ready money for annual dues, but who want to secure the benefits of this program are urged to call at the FSA office, which may be able to assist in the necessary financing, Taggart said.—San Jose *Mercury Herald,* January 24.

50 Families in Tulare County Health Association

Formation of the Tulare County Health Association was completed at a meeting in the Visalia Civic Auditorium, Thursday evening. About fifty charter member families attended and passed on the by-laws and contract with the California Physicians' Service. A board of supervisors was appointed and medical benefits will begin on March 1, 1943.

Applications for membership will be closed for one year after February 14, 1943. The temporary address of the association, for new applications, will be at 129 East Center Street in Visalia. Any farm family, providing that not more than 50 per cent of the family annual income is derived from farming or farm labor may join, if the net family income is $2,000 or less. . . . —Lindsay *News,* January 19.

MEDICAL EPONYMS

Sahli Hemometer

The hemometer was first described by Professor Herman Sahli (1856-1933), of Bern, in a paper, entitled "Über ein einfaches und exactes Verfahren der klinischen Hämometrie [A Simple and Exact Method of Clinical Hemometry]," which was read at the Twentieth Congress for Internal Medicine in April, 1902. The article appeared in *Verhandlungen des Congresses für Innere Medicin* (20:230-234, 1902). A portion of the translation follows:

"After numerous attempts, I have succeeded in finding a method of converting the hemoglobin in a solution of blood into a derivative, by means of a very simple reaction, whereby stable standard solutions can be prepared and colorimetric determinations carried out. . . . The method consists simply in adding to the blood ten times the amount of one-tenth normal hydrochloric acid. After a few seconds, the solution turns deep brown and becomes a clear, brownish yellow after dilution with ordinary water. The pigment content may be colorimetrically determined by means of a similar standard solution, which can be so made as to be completely stable."—

* * *

Shiga-Flexner Bacillus

Kiyoshi Shiga (b. 1870), while assistant at Kitasato's Institute for Infectious Diseases, summarized his conclusions in regard to the bacillus of dysentery in an article, entitled "Ueber den Erreger der Dysenterie in Japan [The Casual Agent of Dysentery in Japan]," dated at Tokio, December 10, 1897. It was published in the *Centralblatt für Bakteriologie, Parasitenkunde und Infektionskrankheiten* (*Abt.* I—23:599, 1898). He speaks of the failures of other investigators who had made use of animal experimentation, attributing this to the fact that most experimental animals are not susceptible to human dysentery. A portion of the translation follows:

"On this account, following the suggestion of Professor Kitasato, I have investigated the subject of dysentery from another angle, namely, as follows: The question arises whether one may not find a microörganism in the stools of patients suffering with dysentery which will show an agglutinating reaction with their blood serum, such as Widal first demonstrated with typhoid bacilli and the serum of patients suffering with typhoid fever. I have made careful bacteriologic examinations of the stools and internal organs of 36 cases of dysentery, and have constantly found one and the same bacillus, which showed a clear-cut agglutinating reaction in the presence of serum of patients with dysentery. . . . I believe that we may probably consider this bacillus as the cause of dysentery."

He describes the cultural characteristics of the organism and further states that the serum of a person injected with the dead culture likewise shows the agglutinating reaction.

On April 12, 1900, Dr. Simon Flexner (b. 1863), professor of pathology at the University of Pennsylvania, delivered a lecture before the New York Pathological Society, entitled "On the Etiology of Tropical Dysentery." This was published in the *Bulletin of the Johns Hopkins Hospital* (11:231-242, 1900). After an exhaustive account of his investigations and a complete review of the symptomatology, bacteriology and pathology of tropical dysentery, including reference to Shiga's work, he concludes:

"I think I have shown that tropical dysentery consists of a bacillary and an amebic form, separable in their early and their later stages by their clinical histories, their etiology and pathological anatomy."—R. W. B., in *New England Journal of Medicine.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1942.

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In March, KFAC will present these broadcasts on the following Saturdays: March 6, 13, 20, and 27.

The Saturday broadcasts of KECA are given at 10:30 a. m., under the title "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.



Charles B. Pinkham, M. D., Retiring Secretary of the California State Board of Medical Examiners. (For editorial comment, see February C. and W. M., on page 58.)

Pharmacological Items of Potential Interest to Clinicians*:

1. *Cancer:* A. Taylor announces successful production of a mammalian tumor by a virus-like principle grown on egg yolk (*Science*, 97:123, Jan. 29, 1943). J. J. Biesele, H. Poyner and T. S. Painter describe nuclear phenomena in mouse cancers (*Univ. Texas Publ.*, 4243, 1942). Most important and impressive is E. S. Sundstroem and G. Michaels' *Adrenal Cortex in Adaptation to Altitude, Climate and Cancer* (Univ. Calif. Mem., Berkeley, 1942, 409 pp. in 4to), which would have made a score of hot journal articles. Proceedings Amer. Assoc. Cancer Research appear in Feb. issue, *Cancer Res.*, (3:120, 1943).

2. *Historical:* Congratulations to J. H. Gaddum on succeeding to the great chair of pharmacology at Edinburgh. He gracefully reviews the development of materia medica there (*Edin. Med. J.*, 49:721, Dec., 1942). H. B. Adelmann edits the *Embryological Treatises of Hieronymus Fabricius of Aquapendente* (Cornell Univ. Press, Ithaca, 1942, 2 vols., 1,000 pp.). Fabricius was the teacher of Harvey.

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

mous Fabricius of Aquapendente (Cornell Univ. Press, 1943). John Fulton prepares Harvey Cushing's Vesalian Notes for the quatrocentennial. John Saunders likewise has ready an annotated translation of the Vesalian *China Root*. The History of Science Society needs your support: Dues $5.00 per year bring *Isis*; remit to A. Pogo, Harvard Library 187, Cambridge, Mass.; it's needed for our culture. J. J. Izquierdo brilliantly describes the Zachheim murals on California's Medical History at the Univ. California Medical Center, San Francisco (Mexico City, 1942).

3. *Books*: B. Harrow's *Biochemistry* (3rd Ed., Saunders, Phila., 1943), looks good. C. C. Thomas issues I. G. Macy's *Nutrition and Chemical Growth in Childhood*. The Interscience Publications furnish E. Gellhorn's *Autonomic Regulations* and W. C. Boyd's *Fundamentals of Immunology*. From Columbia Univ. Press comes E. Mayer's *Systematics and the Origin of Species*. Fisher Unwin (London), issue the remarkable discussion aroused by C. H. Waddington on *Science and Ethics*, in which the Bishop of Birmingham, the Dean of St. Paul's, J. Huxley and yours faithfully participate. From the Univ. of Minnesota Press comes C. M. Christensen's *Common Edible Mushrooms*. Wms. & Wilkins (Balt.), issue D. Rapaport's *Emotions and Memory*. Cattell Press (Lancaster), puts out Vols. 8 and 9 of *Biological Symposia;* R. Redfield's *Levels of Integration in Biological and Social Systems*, and F. C. Koch and P. E. Smith's *Sex Hormones*. Vol. 10 Cold Spring Harbor Symposia appears: *Relation of Hormones to Development*.

4. *Radioactive Elements:* C. Pecher's posthumous classic on the biological effects of radioactive calcium and strontium with a clinical report on their use in bone tumor finally appears (*Univ. Calif. Pub. Pharmacol.*, 2:117, 1942). M. E. Morton and I. L. Chaikoff observe *in vitro* formation of thyroxin by thyroid tissue with radioactive iodine as an indicator (*J. Biol. Chem.*, 147:1, 1943). Symposium on trace elements in relation to health in summarized in *Nature* (151:28, Jan. 2, 1943).

5. *Ends and Odds:* G. G. Villela (*Mem. Inst. O. Cruz*, 37:427, 1942), shows normal urinary excretion of riboflavin varies between 76 and 1300 microg. per day. Sulphonamide resistance in gonorrhea is reviewed by J. Petro (*Lancet*, 1:35, Jan. 9, 1943). L. R. Dragstedt, et al, report on antagonistic effects of lipocaic and anterior pituitary on fat metabolism (*Am. J. Physiol.*, 138:264, 1943). R. L. Noble claims to have produced resistance in rats to amounts of trauma usually fatal (*Ibid.*, p. 346). J. Bronfrenbrenner discusses physical and chemical agents in allergy (*J. Allergy*, 14:105, 1943). R. Granit proposes a physiological theory of color perception (*Nature*, 151:9, Jan. 2, 1943). N. East's Chadwick Lecture on Prevention and Treatment of Anti-Social Behavior is reviewed in *Nature* (151:9, Jan. 2, 1943). P. G. Fuerstner shows reaction of tubes and ovaries to induced vascular spasm (*Univ. Calif. Pub. Pharmacol.*, 2:105, 1942). D. Burk and R. J. Winzler write on vitamers of biotin (*Science*, 97:57, Jan. 15, 1943). J. H. Sandground notes that p-amino benzoic acid reduces toxicity of old pal carbarsone (USP XII!), and similar arsenicals (*Science*, 97:73, Jan. 15, 1943). R. H. Abrahamson and J. W. Hinton discuss the significance of gastric mucosa as an endocrine gland in gastric carcinoma (S.G.&O., 76:147, 1943). Vol. 1 of a series on Effects of Alcohol on the Individual appears from Yale Press, and shows confusion on etiology of addiction.

Erratum.—On page 34 of the January issue of CALIFORNIA AND WESTERN MEDICINE appeared a final vote on Proposition No. 3 (Basic Science Act). It was stated that only three counties cast more votes in favor than against the measure. This was in error, because San Benito County also voted in favor of the Basic Science Act; 1,209 votes being cast in favor thereof and 1,129 ballots against, a difference of 80 in favor of the Act.

Pasadenan Appointed State Health Officer

Dr. Wilton L. Halverson, former Pasadena City Health Officer and for the past year and a half Los Angeles County Health Officer, last night accepted Governor-elect Earl Warren's appointment as State Director of Public Health and said he would probably take over his new duties before the end of January. In announcing the appointment, Warren called Dr. Halverson "one of the outstanding public health men in the country." He has been Los Angeles County public health officer since 1940 and previously was public health officer of Pasadena for seven years. His salary of $6,000 a year will be less than he received in Los Angeles County. He replaces Dr. Bertram Brown, a Hollywood physician....

Born in Litchfield, Minn., June 30, 1896, Dr. Halverson received his bachelor of arts degree from Union College, Nebraska, in 1919. After four years of teaching history at Shelton Academy, Neb., he secured his M. D. at the College of Medical Evangelists.

Studied Many Departments

Through a Rockefeller traveling fellowship grant Dr. Halverson visited and studied many of the best health departments in the United States in 1932. The degree of doctor of public health was conferred on him following completion of a thesis on the subject in which he had become an authority.—Pasadena *Post*, January 5.

S. F. Milk Law Defended Before Supreme Court

Washington, Dec. 17.—(AP.)—Constitutionality of a San Francisco ordinance requiring the pasteurization of all milk sold for human consumption in the city, except certified milk, was defended today before the Supreme Court on the ground that it promoted health.

Henry Heidelberg, deputy city attorney of San Francisco, also contended that the Natural Milk Producers Association of California had no right to challenge the ordinance because the organization had never engaged in the production or distribution of milk in the city.

Other Cities Watching

Describing the Association as a "sort of chamber of commerce of raw milk producers," the attorney said it wanted some edict from this court that will prevent pasteurization ordinances.

"If the decision of the California Supreme Court sustaining this ordinance is affirmed," Heidelberg asserted, "Los Angeles and many other cities will pass pasteurization ordinances at once."

Members of the court displayed interest in a statement by Heidelberg that the San Francisco Medical Milk Commission, which supervised the production of certified milk, had ordered in January, 1939, that all certified milk be pasteurized and had then gone out of existence.

Pasteurization

The effect of this action, the attorney said, was to require that all milk sold in San Francisco for human consumption be pasteurized.

Philip S. Ehrlich, counsel for the Producers' Association, told the tribunal that this action by the Medical Commission was taken at a "secret meeting" and constituted "star chamber proceedings."

"I didn't know anything about it until last Monday," he asserted.—San Francisco *Examiner*, December 18.

New State Director of Institutions

Examiner Bureau, Sacramento, Dec. 28.—Governor-elect Earl Warren today named a second woman to a high position in his forthcoming administration, selecting Mrs. Dora Shaw Heffner of Los Angeles to be State director of institutions.

Mrs. Heffner takes over the $6,000 a year position now held by Dr. F. O. Butler, medical superintendent of the Sonoma State Home, who has been serving as acting director since the resignation of Dr. Aaron H. Rosanoff. . . .—San Francisco *Examiner*, December 29.

Sterilization Operation Plea Raises Shasta Legal Issue

Redding (Shasta Co.), Dec. 11.—District Attorney Laurence W. Carr disclosed today he has been asked by the Shasta County Board of Supervisors to decide on the legality of a sterilization operation on an indigent Shasta County woman in the county hospital.

Carr was informed, he said, the woman, mother of more than a dozen children, had consented to have the operation performed at the county hospital, but Dr. W. L. Bell, county physician, refused to perform the surgery on the ground it is against the law. The woman receives indigent aid here.

Carr said he is studying the law and probably will ask the State's Attorney General for a ruling.

The district attorney said there are two questions of law to be decided: whether the operation is lawful and whether the board of supervisors has the authority to offer such service to an indigent.—Sacramento *Bee*, December 11.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

The Doctor Shortage

Everyone is interested in the so-called doctor shortage occasioned by the enlistment of such a large number in the armed forces of the nation. So far as it can be authentically ascertained, the situation has not become critical in California and steps are being taken to guard against a lack of medical service to the civilian population.

Chico has lost its full share of doctors and those left are being worked nearly up to their capacity. The public is being well served.

A survey just completed by the California Medical Association shows that with few exceptions the communities of this State have enough doctors still in practice to give the civilian population adequate medical care. There are some cities and some rural areas where additional doctors are needed but the relocation of twenty doctors, at the outside, would bring the medical population up to standard in these cases. Dr. Karl L. Shaupp, president-elect of the California Medical Association, announces that the Association expects to handle this relocation work within the next few months. He says that of the State's fifty-eight counties, the association's record shows that only six present any problem because of lack of enough doctors, and only four of these actually need more doctors today and an even dozen could handle these needs. California not only has enough doctors today but it is one of five states in the country still enjoying the luxury of a medical surplus.

In some areas the doctors are pooling their services for emergency medical service. Some districts are being covered by doctors from neighboring cities. In practically all cases the doctors are putting in longer hours and doing more work than they were accustomed to in peacetime.

Assurance is given by Dr. Schaupp that all California will be taken care of in good order by the available doctors.—Chico *Record*, January 23.

My Day—Health Plan For Many

I doubt very much whether we have ever developed the type of medical service which will eventually be useful in China. We are still groping to discover the best ways of reaching our people, all of our people, that is to say, with good medical care.

I received a letter the other day inclosing an article which describes the Group Health Coöperatives, Incorporated. This is a nonprofit medical service corporation in New York City. It is a health insurance plan under which 2,500 physicians in all fields of medicine and surgery offer their services to subscribers at an average cost of two-and-one quarter cents a day.

The basic annual cost to an individual is $9.60 and $24 paid by a family offers surgical care in any hospital, in the doctor's office, or the subscriber's home. It also covers obstetrical care at home or at any hospital, or for any illness not requiring surgical or obstetrical care. This plan, of course, is designed for people with incomes from $1,800 to $3,000. Under certain circumstances, people pay additional amounts for services outside those specified.

Germany was the originator of the insurance principle many years ago. Then Great Britain followed, accepting this as the best method of incorporating Government interest on low income groups as to health and employment. We seem to be following this lead, but there is also the possibility that the need might be met through taxation. It seems to me that a direct health tax bill for all might be a more democratic way of achieving the same results. In any case, I hope we shall examine various ways before making any one of them universal.—E. R.—San Francisco *News*, January 30.

Doctors Urge Food, Not Pills

Although recognizing the value of vitamin preparations, the council on foods and nutrition and the council on industrial health of the American Medical Association recently expressed their disapproval of the mass, indiscriminate administration of vitamins to industrial workers, and suggested that a program aimed at securing industrial health must be based on a proper diet of natural foods.—San Francisco *Pacific Coast Review*, February.

Fresno Doctor Gets State Post: Board of Medical Examiners

Governor Earl Warren today appointed Dr. J. R. Walker, Fresno eye, nose and throat specialist, a member of the state board of medical examiners for a four year term.

Dr. Walker, associated with his brothers, Drs. G. W. and B. F. Walker, has practiced in Fresno since 1902. He is a former president of the Fresno County Medical Society. . . .

He succeeds Dr. W. A. Swim of Los Angeles, whose term expired. Warren has one more appointment to make on the board to fill the post vacated by the expiration of the term of Dr. Fred R. DeLappe of Modesto.—Fresno *Bee*, February 4.

Sex Control in Animal Births Partly Achieved

Chicago, Jan. 29.—(UP.)—The *Journal* of the American Medical Association said today that man can cause males or females to be born at will among some of the lower animals.

Recent research on controlling sex, the *Journal* said, has partly solved a problem that has fascinated mankind since antiquity.

The *Journal* cited experiments by John W. Gowen, and Ronald H. Nelson with a species of fly in which the sex of the offspring "was completely controlled so that 100 per cent males or 100 per cent females could be produced at will."

This, it said, "does establish for the first time on a scientific basis the fact that this can be done experimentally among lower animals by man-devised methods."

The experiments were made with a species of fly known as drosophila, among which is the common fruit fly. The species has been used extensively to study the inheritance of characters and the mechanism of heredity.

"This startling discovery," the *Journal* said, "does not, of course, signify that it will be possible in the foreseeable future for parents to choose in advance the sex of their children."—Oakland *Tribune*, January 29.

U. S. Social Insurance

Chairman Altmeyer Urges Greater Security Benefits

Washington, Jan. 1.—(AP.)—Immediate expansion of the social program to cover all workers, increase benefits under the program now in effect and provide new types of social insurance was urged today by Chairman Arthur J. Altmeyer of the Social Security Board.

Altmeyer, in an article appearing in the board's monthly publication, suggested these three new types of protection:

1. Benefits for permanently disabled workers and for their dependents, irrespective of the worker's age and generally similar in amount to old-age benefits.

2. Benefits for workers temporarily disabled through illness or injury and for their dependents, payable for a limited number of months and more or less similar in amount to unemployment benefits.

3. Payments with respect to hospitalization costs incurred by insured workers or dependents.

These and other suggestions advanced by Altmeyer correspond to recommendations reportedly put before President Roosevelt by the National Resources Planning Board and possibly foreshadow a Presidential message to Congress calling for extension of the social insurance system.

Altmeyer advocated that social insurance coverage be extended to farm labor, domestic servants, seamen, those working in small firms or working for the Government or nonprofit organizations, and the person "who is in business or trade for himself."

"Expansion should provide, in addition, for more nearly adequate benefits under existing programs," he said, adding:

"This end could be achieved by increasing the maximum duration of unemployment benefits, shortening the waiting period, introducing dependents' allowances and increasing benefit amounts.

"An adjustment in the formula for computing old age benefits and a lower retirement age for women under old age survivors' insurance might also appropriately be included."

Altmeyer said that the expansion should be undertaken at once so a "well-rounded system" will be in operation when the war ends, and said it would have two advantages:

1. Protection for individuals and families against the loss of income after the war, "when a decline from the high levels of wartime production would increase greatly the incidence of risks leading to such losses."

2. "From the standpoint of the economic system as a whole, social insurance can aid in maintaining consumer purchasing power if national income exhibits a tendency to shrink and thus can assist in maintaining employment at higher levels."—San Francisco *Chronicle*, January 2.

Social Hygiene's War

While men armed with guns and bullets are fighting the war against our human enemies on the battle fronts, men armed with syringes, drugs and publicity are fighting the war against disease-breeding enemies on the home fronts. These latter men are the doctors, the health officers and the civilian, volunteer members of the American Social Hygiene Association, Inc. The enemies they are fighting, for the protection of our fighting men, are the twin venereal diseases, syphilis and gonorrhea.

All over America this is Social Hygiene Day, so designated to emphasize the battle to keep our armed forces and war workers clean of debilitating infection.

It is a furious and unrelenting fight. It must be waged in every sector where there is a chance of infection. It must include constant public education in the nature of the diseases and their prevention. It must contend against prejudice, ignorance, lust, professional vice and juvenile delinquency. Its fighters must be equipped with clinics for diagnosis and treatment. Its campaigns must be backed by liberal public funds.

Chancellor Ray L. Wilbur of Stanford University, president of the American Social Hygiene Association, said in an address at Buffalo Monday night: "The soldier fighting deadly venereal diseases living in his body fluids or tissues is a second-rater when it comes to fighting the enemies of his country." General John J. Pershing, commander of the AEF in 1917-18, said: "In the last World War venereal disease constituted by far the greatest single threat to the Army's efficiency and morale." In terms of winning the war what applies to the armed forces applies equally to the workers in war industries.

Surgeon General Thomas Parran of the U. S. Public Health Service, Secretary of the Navy Frank Knox and Secretary of War Henry L. Stimson all pay high praise to the American Social Hygiene Association for its work as the panzer division of this home front war.

California Chapters

Last year a San Francisco chapter of the association was formed to localize the fight in this important port of embarkation. Chapters also were established in Los Angeles and San Diego, all three under direction of the California Social Hygiene Association, a branch of the national organization.

In each of these chapters leading citizens have been enlisted as directors. A prime object is to create a public consciousness of the serious nature of the diseases, the preventive facilities available to combat them and support for local health authorities in waging constant war upon them.

Thus are the social taboos that so long suppressed all information about these scourges being broken down and the therapeutic light of reason, understanding and public approval being shed upon measures for their control and, possibly, their ultimate elimination.—San Francisco *News*, February 3.

Moderation, Health and Public Morals Improved in Nine Years

Nine years after repeal of prohibition the nation can count a trend toward moderation and an improvement of public health and morals, according to a survey of statistics assembled to mark the anniversary of repeal of the 18th Amendment.

In 1932, the last full year of prohibition, the crime rate was 1,645 per 100,000 population. Nine years later, the Federal Bureau of Investigation reported the gradual decrease in criminal cases had reached 1,581 per 100,000.

The U. S. Public Health Service says we, as a nation, are healthier than ever before. A report of the Metropolitan Life Insurance Company, issued at the end of the third quarter of 1942, states the year-to-date death rate for its many millions of policyholders is 7.4 per 1,000—an all-time low.

Government sources report that the health of the Army is also better than ever. The rate of Army hospital admissions for alcoholism for 1940, latest year available, was 2.7 per 1,000—a drop of 76 per cent since the peak prohibition year of 1922 when the rate was 11.5 per 1,000.

Reports from the Census Bureau show that the death rate from alcoholism has decreased more than 50 per cent since its prohibition peak in 1928 and in 1941 was 1.9 per 100,000 population.

The National Safety Council reports that deaths from traffic accidents measured against motor vehicle mileage declined 33 per cent since 1925.

The records of social and moral improvements, compiled from official sources by Brewing Industry Foundation, include a Federal report for 1941 showing that bootlegging seizures were reduced 73 per cent since 1929; arrests by Federal agents down 61 per cent. . . . —Maywood *S. E. Herald*, January 21.

TNT Poisoning in War Plants Drops

Cleveland (Science Service), Jan. 22.—American munitions plant workers are in less danger of TNT poisoning than munitions workers of 1917-18, it appears from the report of Dr. Lemuel C. McGee, medical director of the Hercules Powder Co., presented to the Congress of Industrial Health, sponsored by the American Medical Association.

"There is reason to believe," he said, "that recent refinements in methods of manufacture of TNT in America yield a purer product and afford less exposure to the operators than did the methods in vogue in World War I."

One protective device against TNT poisoning, he said, is to begin the shift on a full stomach.

Increased appetite and stomach distress simulating hunger are among the effects of TNT poisoning. Yellowing skin and inflammation are others. Most serious is liver damage, which may lead to death. Early diagnosis and removing the worker from contact with the chemical are essential for reducing mortality from TNT liver damage.—San Francisco *News*, January 22.

'No Medical Crisis in Sight'

Chicago, Dec. 31.—Dr. Morris Fishbein, editor of the *Journal* of the American Medical Association, said today American medical and public health services would continue to function efficiently and effectively through the war.

Writing in the magazine *Hygeia*, Fishbein said, "Fears of a breakdown in American medical and public health services are unwarranted by any evidence now available.

"Far more serious is the attempt to create such fears as a basis for political intrigues or manipulations for political power. That is a dangerous threat to national morale and public health.

"Public attention has been focused on the health of our people by the innumerable investigations of medical manpower. Fortunately the health of our people is now the best it has been in our history. Unless some epidemic, like that of 1918, should sweep the world, these excellent conditions should continue to prevail."—San Francisco *News*, December 31.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Malpractice: Necessity for Expert Testimony as to Propriety of Treatment by Diathermy

The question of first importance presented to the court in any action commenced by a patient against a physician and surgeon to recover damages for the alleged malpractice of the physician, is whether there has been a violation by the defendant physician of the standard of care established by the ordinary training and skill possessed and exercised by physicians and surgeons of good standing practicing in the same or similar communities. As a general rule, it is thoroughly settled in California that the determination of this standard of care, and the degree of skill which must be employed, as applied to and used in a given case, is solely within the knowledge of physicians and surgeons, and the testimony of experts is ordinarily indispensable to establish standards of good practice, and any departure therefrom by a physician or surgeon accused of malpractice. In the usual malpractice case, the patient charges the physician with having been negligent in diagnosis or treatment, and a prerequisite to the establishment of this charge is testimony by a qualified witness that, under the given circumstances, the conduct of the defendant physician was negligent in that it did not conform to standards of care employed by the medical profession.

An apt illustration of this principle is provided by the case of *Trindle v. Wheeler,* 56 A.C.A. 836, decided January 22, 1943, by the District Court of Appeal. The plaintiff in that case employed defendant, a physician and surgeon, to treat her sprained ankle. Defendant prescribed diathermy for the injury, and instructed the experienced and trained nurse assisting him to give the plaintiff a diathermy treatment on the ankle at 3,000 milliamperes for twenty minutes. The nurse placed folded towels on both sides of the ankle against which two electrodes rested. These were connected with the diathermy machine and were held in position by weights. There was nothing to prevent the plaintiff from removing the ankle from contact with the electrodes if the heat became painful. The machine was set in accordance with the physician's instructions and the nurse thereupon left the room. In her absence the diathermy machine increased from 3,000 to 3,500 milliamperes, and the plaintiff suffered burns as a result.

At the trial of the case, the defendant introduced evidence from reputable physicians using diathermy treatments in the locality showing the treatment given was proper for a sprained ankle, was properly administered in accordance with the best practices of the medical profession prevailing in the community, and constituted no departure from this standard of good practice. This evidence was not contradicted by any expert testimony presented on behalf of the plaintiff, but rather the patient attempted to justify her recovery of damages on the doctrine of *res ipsa loquitur* ("the thing speaks for itself"). That is, it was the plaintiff's contention that the mere establishment of the injury during a course of treatment administered by the defendant physician was sufficient to charge him with liability for any damaging results without the necessity of establishing negligence on his part by means of the expert testimony of other qualified persons. The court rejected plaintiff's contention, and ruled that in view of the uncontradicted testimony of defendant's witnesses, that the treatment prescribed, and the manner in which it was administered, were in accordance with the best standards of the medical profession, the plaintiff could not recover damages from the defendant physician in the absence of expert testimony affirmatively establishing the latter's negligence.

In so holding, the court discussed the doctrine of *res ipsa loquitur* in its relation to malpractice cases and recognized its applicability under certain circumstances. This doctrine is a rule of evidence which relieves the plaintiff in a court action of the burden of affirmatively proving the defendant's negligence. Where the doctrine is properly applicable, it is sufficient for the plaintiff to prove the occurrence of the injury which is the subject of the action, and that it occurred while the plaintiff was under the direction of or was receiving treatment from the defendant physician. In the *Trindle* case, the court pointed out the type of situation where the doctrine of *res ipsa loquitur* is properly brought into play, and restricted its application to those cases where scientific knowledge and training are, ordinarily speaking, not required to properly appraise the reasonableness and result of a given course of treatment. One general factual situation which warrants the application of this doctrine is where the action of a physician in treating a diseased or injured portion of a patient's body results in injury to another part of the body which prior to the treatment, was normal and healthy. To illustrate: prior California cases have applied the doctrine where a healthy tooth was knocked from the patient's jaw by the physician in preparing for a tonsillectomy, and again where the patient's uvula and soft palate were cut and damaged by a physician while performing a tonsillectomy. The doctrine has also been applied in cases somewhat similar to the *Trindle* case involving water-bottle or hot-compress burns suffered during postoperative care. As the court pointed out, in these cases the burns were on healthy portions of the patient's body and were not in the areas involved

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

in the medical or surgical treatment. Where such an apparently unjustifiable injury occurs, it would seem reasonable to require the physician to explain the occurrence rather than putting the patient on proof of the defendant physician's negligence.

Applying this reasoning to *Trindle v. Wheeler*, the facts disclose that the burn occurred on the patient's ankle *which was the portion of the body undergoing treatment.* No presumption of negligence could arise from these facts which would excuse the plaintiff in the case from establishing the defendant physician's negligence by affirmative expert testimony given by competent physicians. In the words of the court: "As the necessity for and the method of the use of the diathermy machine in the treatment of a sprain is something that lies entirely outside the experience of the layman, we must conclude that plaintiff may not invoke the doctrine of *res ipsa loquitur* to aid her here." The judgment in favor of the defendant physician and surgeon was affirmed.

Training of Flight Surgeons

The plane is diving 400 miles an hour. The pilot has a split second to destroy his target. If he is physically or mentally only 87 per cent efficient, he is not good enough.

This is the reason for a new branch of medicine, that of the flight surgeon who keeps them fit to fight, taught here at the school of aviation medicine.

The doctors taking the course at Randolph Field in Texas are among America's finest. They will at times fly with their air squadrons, but they are not just flying doctors. Their job is not merely to keep fliers and crews healthy.

These skilled physicians are almost as important as the guns. On them depends whether an American youngster is going to be in shape to out think and out shoot his enemy—whether he will have the personal efficiency for split second decisions.

Altitude Brings Bends

Altitude causes strange body reactions. The drug which may pep a pilot for one task is almost sure to impair him for something else equally vital. Instead of pills and drugs, the flight surgeon is indoctrinated as a scientist, family doctor and personal friend for about three dozen airmen and their crews.

His job is to keep the kids calm, efficient, happy and eager during personal danger, private worries and fatigue the like of which other human beings never have faced, because no other fatigue strikes so fast.

All this never has been taught as one subject in medical colleges. The successful private physicians of yesterday come here to go back to school. Classes begin at 7 A.M. and last until 6 P.M. Interspersed are sections, laboratories and military drill two days a week so they can march like the boys they are going to care for.

Train Like Cadets

These men who for years have told others how to keep pain free enter the big, boiler shaped steel chamber in which, by pumping out the air, they go to a simulated altitude of 38,000 feet — the same as every cadet flier. That means the rarefied air of seven miles aloft, and it means aeroembolism for some—the airman's form of deep sea divers bends.

Aeroembolism begins around 30,000 feet. The doctors get it, and it hurts. It can be dangerous, but also the dangers can be avoided. Doctors take on the experience first hand in order to be able to convince the kids to take their advice.

Every six weeks a class of several hundred doctors is graduated. On Monday morning a new class marches in. The instructors work a fourteen hour day and afterward do some routine duties.

They learn the odd troubles that come from acceleration. The high speed military airmen whose plane swerves and bounces even a little is subjected to brief but high centrifugal pulls. The instructors teach subjects new, intricate and still puzzling to science, whose answers the air surgeons may help to get in future combat flights.

But most important, they teach the human touch of the old family doctor, whose patients are like his children.

'People Rely Too Much Upon Vitamin Capsules'

Chicago, Jan. 14.—(UP.)—Dr. Morris Fishbein, editor of the *Journal* of the American Medical Association, said today that Americans rely too much upon the use of vitamin capsules.

"Man is not made for a diet of pills and capsules," he said.

Dr. Fishbein said that even with stringent rationing the food supply is sufficient to permit everyone an adequate supply of vitamins A and C without taking vitamin capsules, if Americans choose and prepare their foods wisely.

Speaking before the industrial Congress of the American Medical Association, he said people waste enormous quantities of vitamins every day because "the exploitation of the use of vitamins has outstripped by far the knowledge on which such use is based."

The only sound nutrition, he said, depends primarily on proper selection, preparation, consumption and absorption of foods.

"Only by eating foods as a whole can we be certain to secure the necessary amounts of substances which may yet be unknown," he said.

"Americans who are the largest consumers of citrus fruits and tomato juice and who have great quantities of such materials still available, continue to take tablets and other preparations of vitamins, while England and Russia, which are definitely short of these substances, place requests through the lend-lease administration for millions of ounces of ascorbic acid (vitamin C)."

Dr. Fishbein advised government agencies concerned with post-war planning for needy nations, to quickly bring in the advice of scientific bodies to diagnose those nations' nutritional needs so that the treatments may be specific.

The use of vitamins as treatment for disease and certain forms of malnutrition or dietary deficiencies is wholly a professional problem, he said.

"An indiscriminate distribution of large quantities of food," he said, "is wasteful and will not solve the needs of the people concerned as will a scientific study of the primary deficiencies that exist."—San Francisco *News*, January 14.

Young Physicians Are Urged For Rural Areas

Ames (Iowa), Jan. 1.—(UP.)—According to Kaethe Mengleberg, Iowa State College economist, the Iowa farmer's doctor is considerably older than the medic of the city dweller.

Miss Mengleberg says a recent survey which she made shows that 31 per cent of the physicians in rural communities are 65 years of age or over in towns of less than 2,500 population. Only 16 per cent of the doctors in Iowa towns of more than 50,000 are in that age bracket.

In Des Moines, the report shows one-fifth of the doctors in 1940 were less than 35 years old. Only 14 per cent of the doctors in communities of less than 2,500 were under 35 in 1940. . . .—Sacramento *Bee*, January 1.

"Minorities are rich assets of democracy, assets which no totalitarian government can afford. For the majority itself is stimulated by the existence of minority groups. The human mind requires contrary expressions against which to test itself."—Wendell L. Willkie.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 3, March, 1918

EXCERPTS FROM EDITORIAL NOTES

Alarms and Rumors.—From time to time we hear that some member of our organization, who has been unfortunate enough to be sued for some alleged act of unskillfulness or neglectful omission, has suffered grievously at the hands of our organization. The story runs that the Secretary's office was indifferent or careless, or that our legal staff was ineffective and failed to respond to his dire need; or the yarn may be that our finances are impaired, that members are not keeping up their dues, and more and much more of the same. Prefacing the statement, "I heard" or "they say," our informant retails the depressing information. . . .

The point is this: When you hear or see any statement, oral or written, critical or derogatory of your own officers and representatives, do not circulate it, but take it up, either by seeing or writing to the officer or representative criticized, and, if not satisfied with his statement, then take it to the Councillor for your district and ask him to look into the matter for you. . . .

So, we say, criticize your officers and representatives —yes, but do so on facts known to you, and then go to some one in authority. Make your officers and representatives suggestions, they like to get them; but don't aid in the spreading of any rumor designed to disintegrate or weaken our splendid organization—and that, in the possible and probable interest of influences desiring such a result.

Medical Mobilization.—Until the entire medical profession of the United States, so far as its members are mentally and physically fit and within the age limit, is mobilized in the Medical Reserve Corps of the Army, we cannot say that we have done our utmost as a profession in the German war [Year, 1918]. . . .

It is not only for the combatant forces that medical officers are required, but for sanitation, hospital camps, cantonments and in other departments where the health and life of the forces are dependent upon the medical officer. . . .

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "The Work of the Medical Advisory Board for District Exemption Board, Division One, Northern California," by John Gallwey, M. D., San Francisco, Medical Member District Board, California.—On August 6, 1917, at the Capitol in Sacramento, a conference of the District Exemption Boards of California was held. The District Board of San Francisco and Alameda Counties was strongly of the opinion that reëxamination of men claiming physical disability as a basis of appeal, should be provided for by the District Exemption Boards. . . .

The value of the action of the conference of District Exemption Boards of California in providing for expert reëxamination of cases appealing on grounds of physical disability, has been established by the action of the Federal authorities in redistricting the whole country and appointing special boards for each district to continue

(Continued in Back Advertising Section, Page 30)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Governor Earl Warren today appointed Dr. J. B. Walker of Fresno to the State Board of Medical Examiners to replace Dr. W. A. Swim of Los Angeles, term expired. Doctor Walker, an eye specialist, is a member of the National Board of Ophthalmology, and was formerly president of the Fresno Board of Education. He serves until January 15, 1947." (San Francisco *Examiner,* February 5, 1943.)

"Dr. Nathan S. Housman, San Francisco physician who entered San Quentin prison thirteen months ago to serve a perjury term, was paroled yesterday by the State Board of Prison Terms and Paroles. The board, meeting at the prison, set Housman's indefinite term at five years, then granted an automatic parole effective after Housman has served eighteen months. The eighteen months will be reduced, however, by whatever prison 'good time' the board grants Housman, said Mark E. Noon, board secretary. This 'good time' has not yet been credited to him, but it could mean release for the doctor before Christmas. Housman went to prison at the end of a long and spectacular court struggle that began when a wealthy widow died, leaving a will designating him sole legatee. Out of an investigation of the death and the will grew a misdemeanor prosecution of Housman for failure to keep proper records of narcotics prescriptions. Housman won an acquittal, but out of his testimony grew the perjury charge and conviction. Housman cannot return to the practice of medicine because his license was revoked after the felony conviction. He has been working in the prison hospital." (San Francisco *Examiner,* December 10, 1942.)

"'Dr.' Howard Whiteside, operator of a West Seventh Street healing establishment, today had been convicted of practicing medicine without a license by a jury in Municipal Judge Leroy Dawson's court. November 20 was set for probation hearing and sentence. Whiteside was specifically accused of diagnosing a case of two women state operatives, one of whom he said was suffering from a kidney ailment, from eating too much cake in her childhood. He offered to treat her for $150, she testified." (Los Angeles *Herald & Express,* November 14, 1942.)

"Charging that an East Bay cab driver last February drove him against his will to Morgan Hill, forced him to sign a check for $150 and beat him so severely he is still in a hospital, Dr. Thomas W. Welsh, Alameda physician, today filed a $31,000 damage suit in Alameda County Superior Court." (San Francisco *Call-Bulletin,* December 8, 1942.)

"Superior Judge Thomas M. Foley of San Francisco yesterday signed a judgment setting aside, cancelling and annulling action of the State Medical Board, and ordered the Board to issue a license to Dr. Willard S. Edmeades of Martinez. The order is a peremptory writ of mandate reversing the action of the Board in revoking Dr. Edmeades' license for an operation on Mrs. Lenore

(Continued in Back Advertising Section, Page 38)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

The children of VICTORY must be sound and strong



WISCONSIN ALUMNI RESEARCH FOUNDATION
Approved for VITAMIN D upon periodic tests

This Seal *Assures the Vitamin D Potency of Foundation-licensed Products*

From the fire of our present trials will come a new concept of proper nutrition. From the ranks of American children must come the strength, the healthy vigor, and the staunch leadership the world will so sorely need.

No small part of the health and vigor required for these new responsibilities depends upon the development of bodies well formed and strong, upon teeth that are sound and healthy. And these largely depend upon how well Vitamin D is given the chance to mobilize food-calcium for bone and tooth structure. Calcium is also needed for its vital mission with relation to muscle tone, nerve function, blood clotting, and normal heart action.

The Foundation Seal, or the imprinted name of the Foundation itself, is assurance that all foods and pharmaceuticals so identified can be accepted as wholly reliable sources of Vitamin D, tested periodically for potency.



WHAT IS THE FOUNDATION?—Let us mail you the booklet, *Scholars from Dollars*, the story of the Foundation and its work. Established in 1925, not for private profit, the Foundation receives and administers patentable discoveries, voluntarily assigned. Through licensing arrangements with reliable concerns, funds are obtained. All net avails are devoted to the furthering of research. Foundation trustees serve without compensation. Send for your copy of *Scholars from Dollars* . . . today.

WISCONSIN ALUMNI RESEARCH FOUNDATION, MADISON, WISCONSIN

French Hospital

Geary Boulevard and
Fifth Avenue
SAN FRANCISCO,
CALIFORNIA



A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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86c out of each $1.00 gross income used for members' benefit

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

Hospital, Accident, Sickness
INSURANCE

For ethical practitioners exclusively
(57,000 Policies in Force)

LIBERAL HOSPITAL EXPENSE COVERAGE	For $10.00 per year
$5,000.00 ACCIDENTAL DEATH $25.00 weekly indemnity, accident and sickness	For $32.00 per year
$10,000 ACCIDENTAL DEATH $50.00 weekly indemnity, accident and sickness	For $64.00 per year
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41 years under the same management

$2,418,000 INVESTED ASSETS
$11,350,000 PAID FOR CLAIMS

$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

Send for applications, Doctor, to
400 First National Bank Building . Omaha, Nebraska

BOOK REVIEWS

(Continued from Front Advertising Section, Page 22)

to the evacuation hospital and the duration of evacuation may fluctuate within wide limits, there are only two safe methods of checking a severe external hemorrhage, i.e., ligature and forcipressure. . . .

Basic indications for immediate operation are clinical symptoms pointing to progressive intra-abdominal hemorrhage or hollow viscus penetration. . . .

In military surgery the onset of septicemia may be so rapid that, even when the primary focus of infection is discoverable and removable through debridement, drainage or relief of tension, little or no improvement may follow. . . .

Gas gangrene is still one of the most dreaded of military infections. . . .

Tetanus will also claim the immediate attention of front-line surgeons. . . .

The Pharmacopoeia of the United States of America. Twelfth Revision (U.S.P. XII). By Authority of the United States Pharmacopoeial Convention. Prepared by the Committee of Revision and Published by the Board of Trustees. Official from November 1, 1942. Easton, Pa.: Mack Printing Company.

In January, 1817, Dr. Lyman Spalding, of New York City, submitted to the Medical Society of the County of New York a project for the formation of a National Pharmacopoeia.

Doctor Spalding's plan was as follows: The United States was to be divided into four districts—Northern, Middle, Southern, and Western. . . .

The plan provided that a Convention should be called in each of these districts, to be composed of delegates

(Continued on Page 28)

The doctor* oughta know about this...



WITH an empty Karo bottle, the baby has a right to complain. And perhaps, Doctor, so have you. We admit that occasionally grocers do not have Karo syrup.

The situation is this: The great demand for Karo by the armed forces and a huge increase in domestic needs so tax our capacity that we are not always able to keep all grocers supplied.

We cannot step up quantity any further without letting down on quality and this we will *never* do.

If any patient complains that she is unable to obtain Karo for her babies, please tell her to write us direct, giving us the name and address of her grocer and we will promptly take steps to provide this grocer with Karo.

CORN PRODUCTS REFINING COMPANY
17 Battery Place, New York, N. Y.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods



* INCIDENTALLY, Doctor, Red Label Karo and Blue Label Karo are interchangeable in standard feeding formulas. Their chemical composition is practically identical; their caloric values are equivalent. So if your patients cannot get the flavor you prescribe, please suggest that either Blue or Red Label may be used.

May We Suggest CALSO WATER for the Urologists

Indications

For all Genito-urinary infections, particularly the irriated bladder of Prostatics

Pre- and Postoperative Treatment

Fluid Depletion

Indicated in combinations with Sulfa therapy

Formula

Calcium Carbonate
Magnesium Carbonate
Sodium Chloride
Sodium Phosphate
Sodium Bicarbonate

Sparkling Palatable Not a Laxative

•

THE CALSO COMPANY
524 Gough St., San Francisco, Calif.

CALSO WATER is not a laxative.

PROFESSIONAL PROTECTION

SINCE 1899 SPECIALIZED SERVICE

In addition to our Professional Liability Policy for private practice, we issue a special MILITARY POLICY to the profession in the Armed Forces at a Reduced Premium

THE MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA



Telephone
MAYFAIR 321

ALUM ROCK SANATORIUM
FOR DISEASES OF THE CHEST
SAN JOSE, CALIFORNIA

A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician receives regular clinical reports.

Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

Resident Staff:
Buford H. Wardrip, M. D.
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Harold Guyon Trimble, M.D., Oakland
Cabot Brown, M.D., San Francisco
J. Lloyd Eaton, M.D., Oakland
Gerald L. Crenshaw, M.D., Oakland
Philip H. Pierson, M.D., San Francisco
Glenroy N. Pierce, M.D., San Francisco
Ina Gourley, M.D., Oakland

BOOK REVIEWS

(Continued from Page 26)

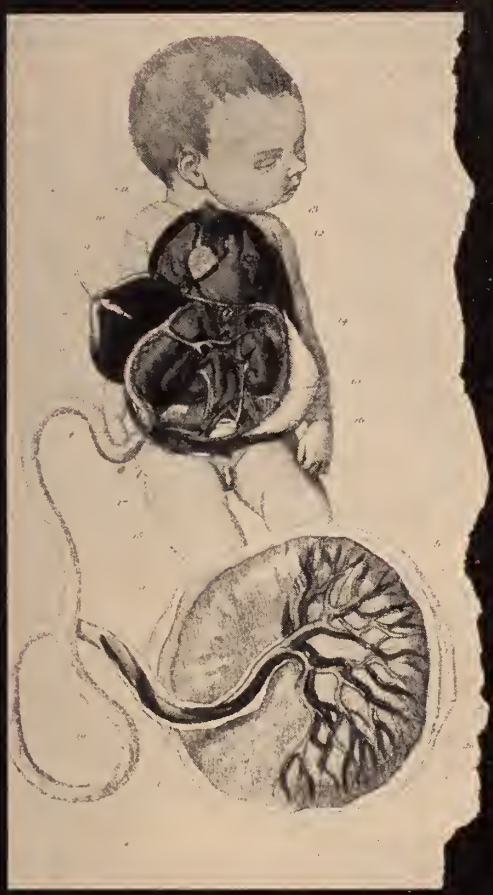
from all the medical societies and schools situated within each of them. Each District Convention was to form a Pharmacopoeia, and appoint delegates to a General Convention, to be held in Washington, D. C. To this General Convention the four District Pharmacopoeias should be taken, and from the material thus brought together a National Pharmacopoeia should be compiled. . . .

Before adjourning, the General Convention of 1820 made arrangements for the future revisions of the work. . . .

The new Eleventh Revision of the Pharmacopoeia became official on June 1, 1936, but the rapidity of scientific and medical advances was such that it was found desirable to issue two Supplements, which became official on December 1, 1937, and January 1, 1940, respectively. By this means the Pharmacopoeia endeavored to maintain its scope and standards in harmony with current developments in medicine, pharmacy, and the related sciences.

The revised Federal Food, Drug and Cosmetic Act, passed in 1938, again recognized the United States Pharmacopoeia as an official compendium, and the new provisions of this act greatly increased the responsibilities of the Revision Committee. To meet these new demands upon the Pharmacopoeia, it was proposed that two revisions of the Pharmacopoeia be published during the next decade, and also Interim Revision Announcements or Supplements covering new items or revised standards, whenever, in the opinion of the Committee of Revision and the Board of Trustees, these are believed to be necessary. This program is made possible by the adoption of the plan of "continuous revision." . . .

(Continued on Page 30)



This interesting study of fetal circulation is taken from Antonin Bossu's Anthropologie Etude des Organes, Fonctions, Maladies de l'Homme et de la Dame published in Brussels in 1847.

FOR COMPLICATIONS AS OLD AS TIME

IF NEED for stimulation of labor arises in delivery rooms, obstetricians often rely upon Pitocin*, an oxytocic of many advantages and dependable performance.

Pitocin consists of the oxytocic principle of the posterior pituitary gland with practically none of the pressor hormone. Its extremely low protein content so minimizes possibility of systemic reaction that many physicians prefer Pitocin for routine management of obstetric patients.

Pitocin is indicated for stimulation of uterine musculature in uncomplicated obstetrics, increasing tone of the uterus by direct action. It is widely used in uterine inertia during the second stage and to check uterine hemorrhage.

Pitocin

a product of modern research offered to the medical profession by

PARKE, DAVIS & COMPANY

DETROIT, MICHIGAN

*Trade-mark Reg. U. S. Pat. Off.

The Alexander Sanatorium, Inc.

Situated in the Foothills of
BELMONT, CALIFORNIA

Specialized care of Convalescents; also NERVOUS, MENTAL and ALCOHOLIC Patients. Experienced Staff for the application of INSULIN and ELECTRIC SHOCK Therapies and for the CONDITIONED REFLEX TREATMENT of ALCOHOLISM.

Recognized by the American Medical Association; Member of Association of Private Mental Hospitals and of the Western Hospital Association.

MRS. A. S. ALEXANDER, *President* Telephone: Belmont 40



Las Encinas Sanitarium . . . Pasadena, California
INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES
Board of Directors: GEORGE DOCK, M. D., *President;* J. ROBERT SANFORD, M. D., *Vice-President*
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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOOK REVIEWS

(Continued from Page 28)

This standard work is a valuable addition to every collection of medical books.

Synopsis of Pathology. By W. A. D. Anderson, M.A., M.D., Assistant Professor of Pathology, St. Louis University School of Medicine; Pathologist, St. Mary's Group of Hospitals. Leather. Price $6.00. Pp. 661, with 294 Text Illustrations and 17 Color Plates. St. Louis: The C. V. Mosby Company, 1942.

This volume is intended to fill a gap which has existed between the very elementary manuals of pathology and the abundant excellent larger textbooks and reference works. By the presentation of pathology in a compact and condensed form, it is designed to be useful to the medical student, to the dental student studying general pathology, and to the clinician who must maintain familiarity with the foundation sciences of medical practice.

Modern pathology has a combined base of anatomy, histology, embryology, physiology, biochemistry, and bacteriology and forms an essential linkage with clinical medicine, and this volume aims to properly emphasize the relationships.

Fundamentals of Psychiatry. By Edward A. Strecker, M.D., Sc.D., F.A.C.P., Professor of Psychiatry and Chairman of the Department, Undergraduate School of Medicine, University of Pennsylvania; Psychiatrist to the Pennsylvania Hospital; Attending Psychiatrist, Psychopathic Division, Philadelphia General Hospital. Cloth. Price $3.00. Pp. 201, with 15 illustrations. Philadelphia, Montreal and London: J. B. Lippincott Company, 1942.

In the conception of psychosomatic medicine which has now attained much prominence, internal medicine and its subdivisions have acknowledged the leadership of psychiatry and the authenticity of its "mind-body" teachings.

The concept of psychosomatic medicine is very ancient. As long ago as the fifth century, B. C., Socrates, returning from the Thracian campaign, praised the wisdom of the physicians of Thrace in their understanding and application of the principle that the body could not be relieved of symptoms, without first curing the mind. He adjured the physicians of Greece to do likewise. . . .

Psychiatry has utilized the opportunities of each new era and trend as it emerged—humanitarianism, descriptive psychiatry, somatic explorations, psychogenesis, psychosomatogenesis. . . .

To bring this body of information, in usable form, to the medical student and practitioner is the purpose of this book. . . .

TWENTY-FIVE YEARS AGO

(Continued from Text Page 154)

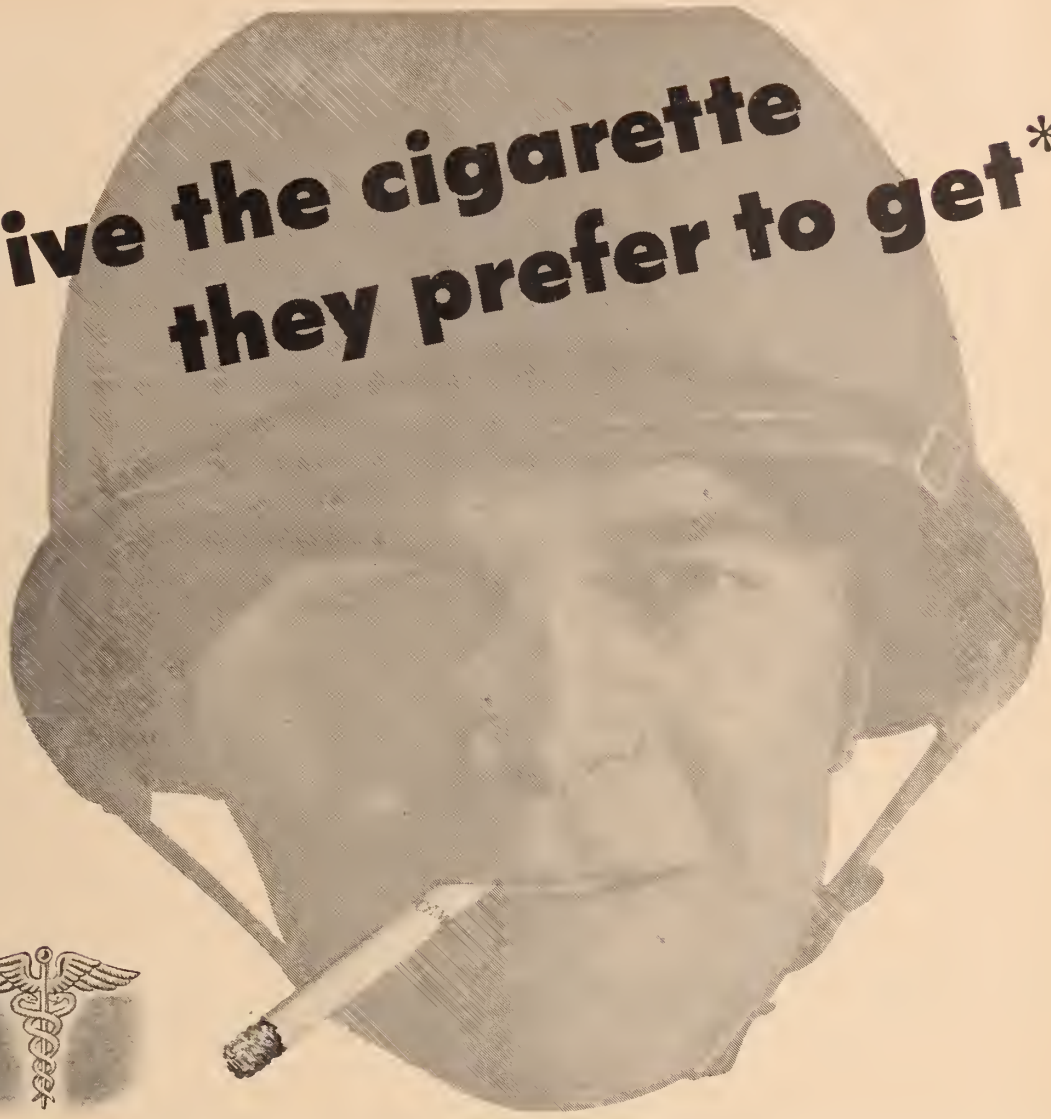
this work. . . .

From an Article on "Non-Beverage Alcohol," by Felix Lengfeld, Ph. D., San Francisco.—The Food Conservation Act practically prohibits the distillation of alcohol for beverage purposes after September 9th, 1917. The War Revenue Act imposes a higher tax on beverage than on non-beverage alcohol. . . .

To get a permit, the physician must fill out a form of application which he must obtain from the Collector of Internal Revenue, and must file a bond in the sum of approximately $6.00 for each gallon of alcohol he is liable to have in his possession. . . .

(Continued on Page 32)

Give the cigarette they prefer to get*



IT'S EASY to understand why cigarettes are the preferred gift in the armed services. But did you know that among them the best-liked brand* of cigarette is Camel? Camel is the popular choice of millions and millions of smokers for its finer flavor and superior mildness.

Send Camels, the service man's favorite, to those friends or relatives who are fighting our battles —fighting them efficiently and unselfishly. Your thoughtfulness will be appreciated.

Tobacco stores feature Camels by the carton. See or telephone your dealer today.

Remember, you can *still* send Camels to Army personnel in the U. S., and to men in the Navy, Marines, or Coast Guard *wherever they are.* The Post Office rule against mailing packages applies only to those sent to the overseas Army.

* With men in the Army, the Navy, the Marine Corps, and the Coast Guard, the favorite cigarette is Camel. (Based on actual sales records in Post Exchanges and Canteens.)

Camel

costlier tobaccos





WORKING EYES IN 1943

Need Orthogon

The tempo of a fighting America in '43 is beat out by punch presses and air hammers—"we can, we will, we must." But no worker is better than his eyes. Vision for Victory is your job, a job completed only when every producer has eyes working at top efficiency. That means skillful refraction and top-quality optical products. Such as Orthogon lenses, prescription-finished in our shops. *In Soft-Lite, too*

RIGGS OPTICAL COMPANY

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A Limited General Hospital of 200 Beds

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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

From an Article on "Pyelograms of Tumors of the Kidneys," by Granville MacGowan, Los Angeles.—Pyelography is sometimes of marked assistance in differentiating doubtful neoplasm or polycystic kidney from inflammatory conditions. The characteristic feature of pyelography is the reproduction of the outline of the pelvis of the kidney and its calyces obtained by this photographic device. The pelvis of the healthy kidney follows a certain familiar outline, as do also its calyces. . . .

Excerpts from Letters of Dr. Geo. J. McChesney to Dr. Harry M. Sherman, San Francisco:

New York, Oct. 8, 1917.

Letter No. 1:

Well, I am not allowed to tell when I am sailing, from where, where to, or what, or anything about the trip over such as attacks real or imaginary. (The last is verbatim.) However, I will say that the date is imminent to say the least. . . . One does not see as many uniforms on the street here as in S. F. They are down at the Long Island training camps. . . .

* * *

France, Nov. 3, 1917.

Letter No. 2:

Am settled in France at last. My stay in England was quite brief, only awaiting orders in London for transportation to my present station which is with the St. Louis Base Hospital at Rouen, to observe the acute side of orthopedics in preparation for similar work in U. S. Orthopedic hospitals when established.

(Continued on Page 34)

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TWENTY-FIVE YEARS AGO

(Continued from Page 32)

We had an uneventful though slow and tedious trip across. . . .

* * *

London, Jan. 4, 1918.

Letter No. 3:

I have been ordered back to London, arriving here a week ago after a cold but uneventful trip from Rouen. . . . As we did not have to report to our present station at Shepherd's Bush Military Orthopedic Hospital for three days, we saw some theaters and did some much needed shopping and reposing in comfortable beds in warm rooms, quite a change after our lodging in France. Everything quits here during the holidays and even now the work at this hospital is barely picking up. We arrived at the hospital on the 31st just in time for New Year's Eve celebration, consisting of a turkey dinner and fancy dress ball of all the doctors and half the nursing staff. The next night we doctors had to go through it all again with the other half. Even I had to dance although I had quit ten years ago. Don't talk to me about poor, sad England. Everything quits around the holidays, two days' celebration at Xmas and Boxing Day and two days at New Year's. Theaters and shops are doing a big business right along, although we notice some food shortage in London, skimpy butter and sugar rations.

Excerpts from the Minutes of the Los Angeles County Medical Association Meeting:

Social Health Insurance.—Dr. John R. Haynes spoke briefly on Workmen's Compensation Act, and approved

(Continued on Page 36)



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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

of the same, saying that because of its success Governor Johnson appointed a committee and favored an amendment to the constitution in order that State Social Health Insurance may also become a law.

Mrs. Frances C. Noel, a Commissioner of State Social Health Insurance, said the Governor was urged to appoint the commission by civic workers who had made a study of it, and that it dates back to group insurance of the twelfth century. She paid a high compliment to the secretary of the commission, Mrs. Barbara Nachtrieb-Grimes, by graciously deferring the subject to her. Mrs. Nachtrieb-Grimes, a charming lady with a pleasing delivery, won the hearts of the medical fraternity present, and captured their scientific minds by her convincing and lucid presentation. All the supposed opposition to Health Insurance seemed to vanish and the idea of holding hands with Christian Scientists to defeat the measure caused a good-natured ripple of laughter. Some questions were asked, rather for information than discussion.

Dr. C. P. Thomas said he feared the plan because of his experience with the operation of accident insurance. Mrs. Grimes agreed fully, but pointed out that Health Insurance will not be run for the benefit of insurance companies. . . .

Dr. Charles C. Browning moved that twelve members be appointed by the president for the study of the subject. Dr. Geo. H. Kress reminded Dr. Browning that he himself had appointed a committee while in office. Dr. Wenzlick, as chairman of that committee, mentioned that the committee had reported a year ago, but little interest was shown in the matter at that time, and that the report will appear in the February issue of the *California State Journal of Medicine.*

Mrs. Frances N. Noel, member of the California State Social Health Insurance Commission, stated that the impression has been created that Social Health Insurance is a purely Germanic idea. This is erroneous, for Social Insurance is in reality nothing but workmen's insurance, and as such dates back as far as the twelfth century. . . .

MRS. NOEL STATED:

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(Continued from Text Page 154)

Garner, former Martinez night club entertainer. . . ." (Pittsburg *Independent,* November 19, 1942.)

"Senator Jack B. Tenney of Los Angeles, charging that his 'little Dies' committee uncovered evidences of physicians belonging to subversive organizations, today prepared to introduce a measure empowering the State Medical Board to revoke the licenses of doctors who engage in unAmerican activities." (Press dispatch dated Sacramento, January 27, 1943, printed Fresno *Bee,* January 27, 1943.) (The bill referred to is Senate Bill 589.)

Six Audience Enemies

In a recent issue of *Science,* Eugene G. DuBois, of the Department of Physiology, Cornell University Medical College, writes an interesting discussion on, "The Reading of Scientific Papers."

DuBois says that the chairman of scientific or medical meetings should have the title of "Sole Protector of the Audience." He says that the audience is helpless when confronted by speakers with poor delivery, poor slides and poor material. He classified these "audience enemies" from one to six as follows:

1. The Mumbler, who is handicapped by poor habits of speech, an incorrectly placed voice or an inherent nervousness. Bad delivery is caused by lack of consideration in a man who is more interested in excreting words than in conveying information. When he turns

(Continued on Page 42)

★ ★



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(Continued from Page 38)

to the screen and talks at the chart he is paying more attention to his own achievements than to the audience. This is particularly disastrous if he wanders away from the microphone.

2. The Slide Crowder, who wishes to show just as much of his data as possible, and thus demonstrate his industry, who prepares many slides from typewritten sheets, because this is the easiest method, who ignores the fact that the typewriter has the worst possible type for display at a distance, who competes with a slide by employing one of the modern flashlights with a bright arrow that dances all over the screen and ceiling. There is nothing in black and white that has a chance of holding the eye when a bright arrow swoops and darts like a hornet.

3. The Time Ignorer who exceeds the limit set by the program and is purely selfish or else over-impressed with the idea that his paper is much more important than the program committee had imagined.

4. The Sloppy Arranger who selects the method of presentation best calculated to confuse the audience, who may have in the back of his head the idea that he can lead up to a climax and hold the audience in breathless suspense until in the very last sentence he may prove that the venous blood of the wimpus contains only 3 milligrams of gadgetyl cloride instead of 4 milligrams. Would it not be kinder to the audience if he followed newspaper technique and gave in a headline, early in the talk, some idea as to what and wherefore?

5. The Lean Producer whose paper consists of trivia, errata, omissia, et cetera; mostly et cetera.

6. The Grasping Discussor who can spoil almost any meeting, who has been invited to open the discussion and has probably prepared a nice little paper of his own with scant reference to the paper of the evening, or who just happens to have in his pocket some lantern slides that he would like to show, for a few minutes.—*Jackson County Medical Society Bulletin.*

Tuberculosis

Control of tuberculosis under conditions of war challenges all available resources. The medical history of World War I reveals to us how mortality rates for tuberculosis increased greatly during the war and some years thereafter, especially in Europe. The massing of armed forces for training purposes, mixing individuals from areas of high tuberculosis prevalence with those from areas relatively free of the disease, confronts the military establishment as one problem in tuberculosis control. The concentration of families of industrial workers in defense and cantonment areas, under unhygienic living conditions where sanitation is limited or absent, presents another terrific health problem. Unless national efforts are directed towards combating these specific factors in the tuberculosis problem, we may well expect an upward trend rather soon in the tuberculosis mortality curve for the United States which has had a beautiful downward trend from 114 per 100,000 per year in 1920 to 45.9 in 1940.—Herman E. Hilleboe, P. A. Surgeon-in-charge, Tuber. Control, States Relations Division, United States Pub. Health Serv.



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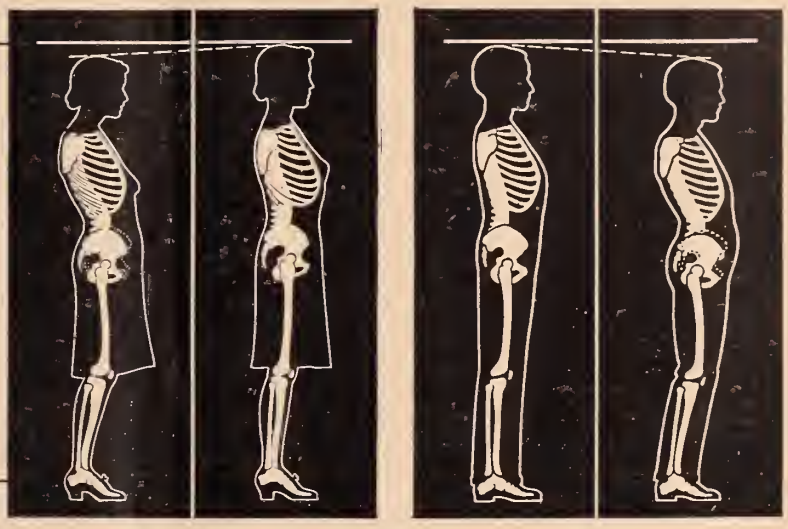
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(Continued on Page 5)

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2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
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Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
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Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

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Secretary, Jerome A. Thormann, Power Company Building, Fresno.
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Meeting, *First Thursday.*

Imperial County Medical Society
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Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

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Secretary, Joseph W. Telford, Bishop.
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Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

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President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
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Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

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Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

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1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2212 W. 3rd Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

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President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.*
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

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Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. Don Rolph, 640 National Ave., National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Rohles.
Secretary, Harrison Eilers, 1009 Morro, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barhara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie, 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

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President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
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Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
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(Roster lists continued on advertising Page 6)

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(Continued from Page 3)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

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Hospital Service of California, 153 Kearny Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

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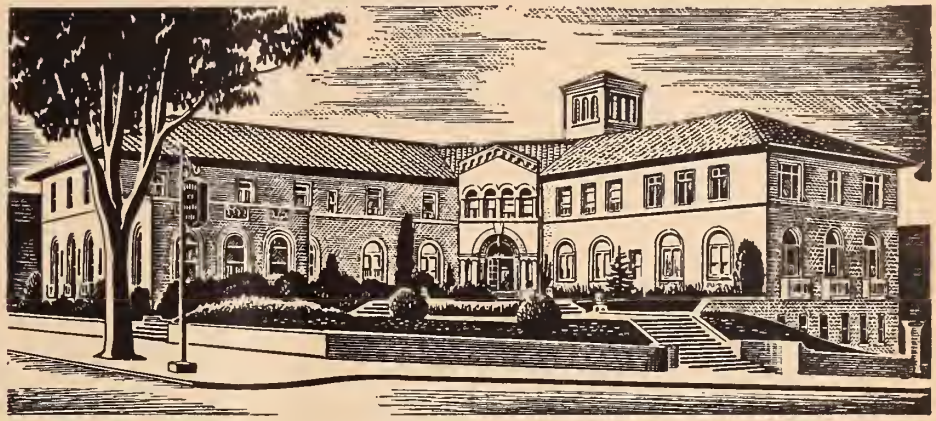
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Essentials of Proctology. By Harry E. Bacon, B.S., M.D., F.A.C.S., F.A.P.S., Professor and Head of the Department of Proctology, Temple University Medical School and Hospital; Head of Department of Proctology, St. Mary's Hospital; Consulting Proctologist, Rush Hospital, National Stomach Hospital, Douglass Hospital, Mercy Hospital, and Paul Kimball Hospital, Lakewood, N. J.; Fellow, International College of Surgeons. Introduction by Curtice Rosser, B.A., M.D., F.A.C.S., F.A.P.S., Professor of Proctology, Baylor University, Dallas, Texas. Cloth. Price $3.50. Pp. 361, with 168 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Eye Hazards in Industry: Extent, Cause, and Means of Prevention. By Louis Resnick. Published for the National Society for the Prevention of Blindness. Cloth. Price $3.50. Pp. 321, illustrated. New York: Columbia University Press, 1941.

The Vertebrate Eye and Its Adaptive Radiation. By Gordon Lynn Walls, Research Associate in Ophthalmology, Wayne University College of Medicine. Cranbrook Institute of Science, Bulletin No. 19, August, 1942. Cloth. Price $6.50. Pp. 785, illustrated. Bloomfield Hills, Michigan: The Cranbrook Press.

Chemotherapy of Gonococcic Infections. By Russell D. Herrold, B.S., M.D., Associate Professor of Surgery (Urology) College of Medicine, University of Illinois, Chicago, Illinois. Cloth. Pp. 137. St. Louis: The C. V. Mosby Company, 1943.

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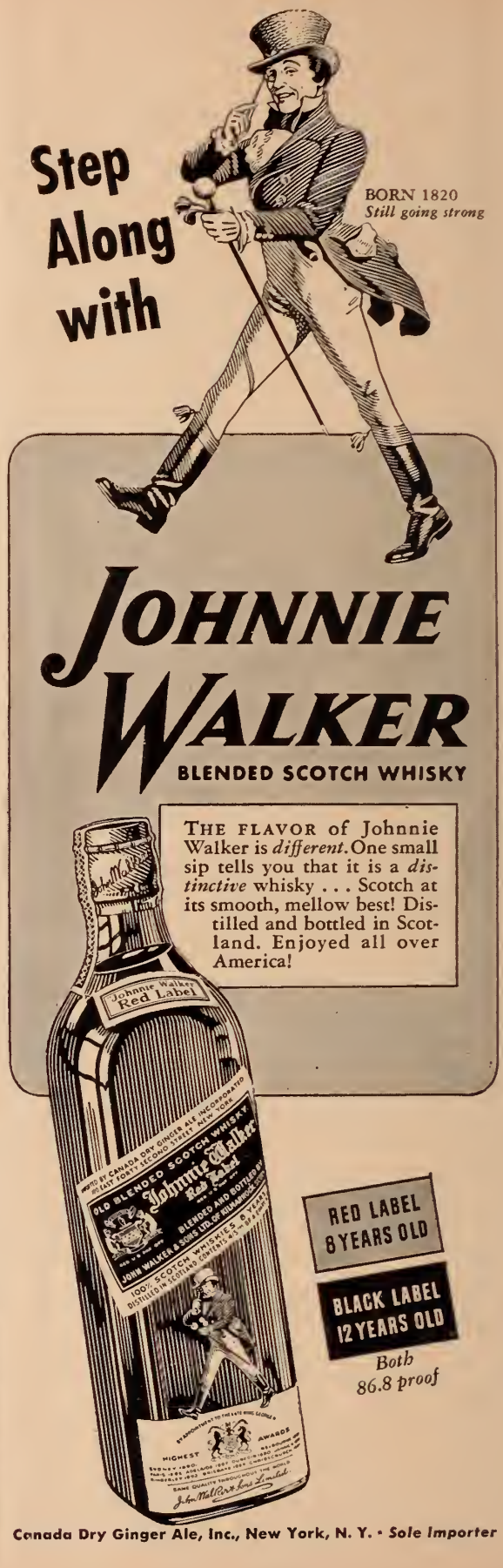
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The Principles and Practice of War Surgery. With Reference to the Biological Method of the Treatment of War Wounds and Fractures. By J. Trueta, M.D., formerly Director of Surgery, General Hospital of Catalonia, University of Barcelona; Assistant Surgeon (E.M.S.) Wingfield-Morris Orthopaedic Hospital, Oxford: Acting Surgeon-in-Charge, Accident Service, Radcliffe Infirmary, Oxford. With Introduction by Owen H. Wangensteen, M.D., Minneapolis, Minn. Cloth. Pp. 439, with 144 text illustrations. St. Louis: The C. V. Mosby Company, 1943.

Man in Structure and Function. By Fritz Kahn, M.D. Translated from the German and edited by George Rosen, M.D. In two volumes. Cloth. Price $10.00. Pp. 742, with illustrations. New York: Alfred A. Knopf, Inc., 1943.

Diseases of the Nose, Throat and Ear. By William Lincoln Ballenger, M.D., F.A.C.S., late Professor and Head of the Department of Otology, Rhinology and Laryngology, School of Medicine, University of Illinois, Chicago; and Howard Charles Ballenger, M.D., F.A.C.S., Associate Professor of Otolaryngology, Northwestern University School of Medicine, Chicago; Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois. Eighth Edition, thoroughly revised. Cloth. Price $12.00. Pp. 975, illustrated with 604 engravings and 27 plates. Philadelphia: Lea & Febiger, 1943.

Gregg Medical Dictation Series: Volume 8 Urology. By Marie Zweegman Yates, Director, Zweegman School for Medical Secretaries, San Francisco, California. Experimental Edition. Paper. Price $1.00. Pp. 81. New York, Chicago, Boston, San Francisco: The Gregg Publishing Company, 1943.

BOOK REVIEWS

The Vertebrate Eye and Its Adaptive Radiation. By Gordon Lynn Walls, Research Associate in Ophthalmology,

(Continued on Page 13)



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(Continued from Page 10)

Wayne University College of Medicine. Cranbrook Institute of Science, Bulletin No. 19, August, 1942. Cloth. Price $6.50. Pp. 785, illustrated. Bloomfield Hills, Michigan: The Cranbrook Press.

This comprehensive monograph fills a void in ophthalmic literature and definitely amplifies ophthalmic knowledge and interpretation. Walls is widely known for his contributions to comparative ophthalmology, but this presentation is intended for any and all of the scientifically-minded public that may be interested. Assuming no more background than that acquired in an elementary course in biology, the author writes in a simple, progressive style, with a stimulating originality both in viewpoint and expression. Beginning with a comprehensive discussion of the human eye, he explains in detail its ontogenetic and phylogenetic relationships. The evolutionary responses of the vertebrate eye to various environmental factors are next considered "Everything in the vertebrate eye means something." Animal color vision is treated at particular length. The final section is a systematic survey of the eye from the lowest living vertebrates to the highest "The animal as a whole explains much about its eye, and in turn the eye can often explain much about the animal."

Vertebrate vision is more than just photoreception. A worm may react to a light stimulus without having a sensation or consciousness of light. "Human vision is the product of a complex brain teamed with a relatively simple eye." In lower forms more complex eyes connected with simpler brains probably offer the animal mind much more than the latter can assimilate.

This is an unpedantic, scholarly work of first magnitude, written as a fascinating lecturer talks—clearly, vividly, and with human touch.

J. E. L.

The Sight Saver. By C. J. Gerling. Cloth. Price $2.00. Pp. 202. New York: Harvest House, 1943.

The cover jacket of the book states that "It covers the subject of sight conservation from every angle, without invading the province of the family physician or the eye specialist. Virtually everything from A to Z is here, and the language is as simple and understandable as the information is conservative and accurate."

The presentation, arranged alphabetically as in an encyclopedia, is convenient for reference, but the material would probably carry greater interest to the general public, for whom it was written, if treated in the conventional manner. The captions dealing with glasses, ocular hygiene and quackery are especially commended for up to-date authentic and ample data. The title of the book is unfortunately ambiguous, and possibly misleading.

J. E. L.

Fractures of the Jaws and Other Facial Bones. By Glenn Major, B.S., A.M. (in Pathology), M.S. (in Experimental Surgery), Ph.D. (in Surgery), D.D.S., M.D., F.A.C.S., Pittsburgh: with Chapters on Radiographic Technique, by Lester M. J. Freedman, B.S., M.D., formerly Assistant Radiologist, Department of Diagnostic Roentgenology; now Acting Director, Department of Radiation Therapy, the Western Pennsylvania Hospital, Pittsburgh; and War Aspects of Jaw Fractures, by Arthur Dick, D.D.S., M.D., Major, Medical Corps, Army of the United States. Cloth. Pp. 446, with 225 illustrations. St. Louis: The C. V. Mosby Company, 1943.

The volume should appeal equally to members of the medical and dental professions, stressing as it does the necessity for these members to understand the problems peculiar to each other's profession.

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(Continued on Page 16)

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Kantor, J. L.: Digestive Disease and Military Service, Jnl. A. M. A., Sept. 26, 1942.

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BOOK REVIEWS

(Continued from Page 14)

maxillary fractures contains discussion of sufficient types of fixation apparatus to well cover this subject.

The division on special fractures and their handling is excellent as is that on complications. Radiographic technique is a valuable practical guide contributed by one of the collaborators.

Likewise the section on war aspects of jaw fractures, intended for the military dental surgeon, contains much of value and rightly emphasizes the necessity for coöperation between the plastic surgeon and dentist.

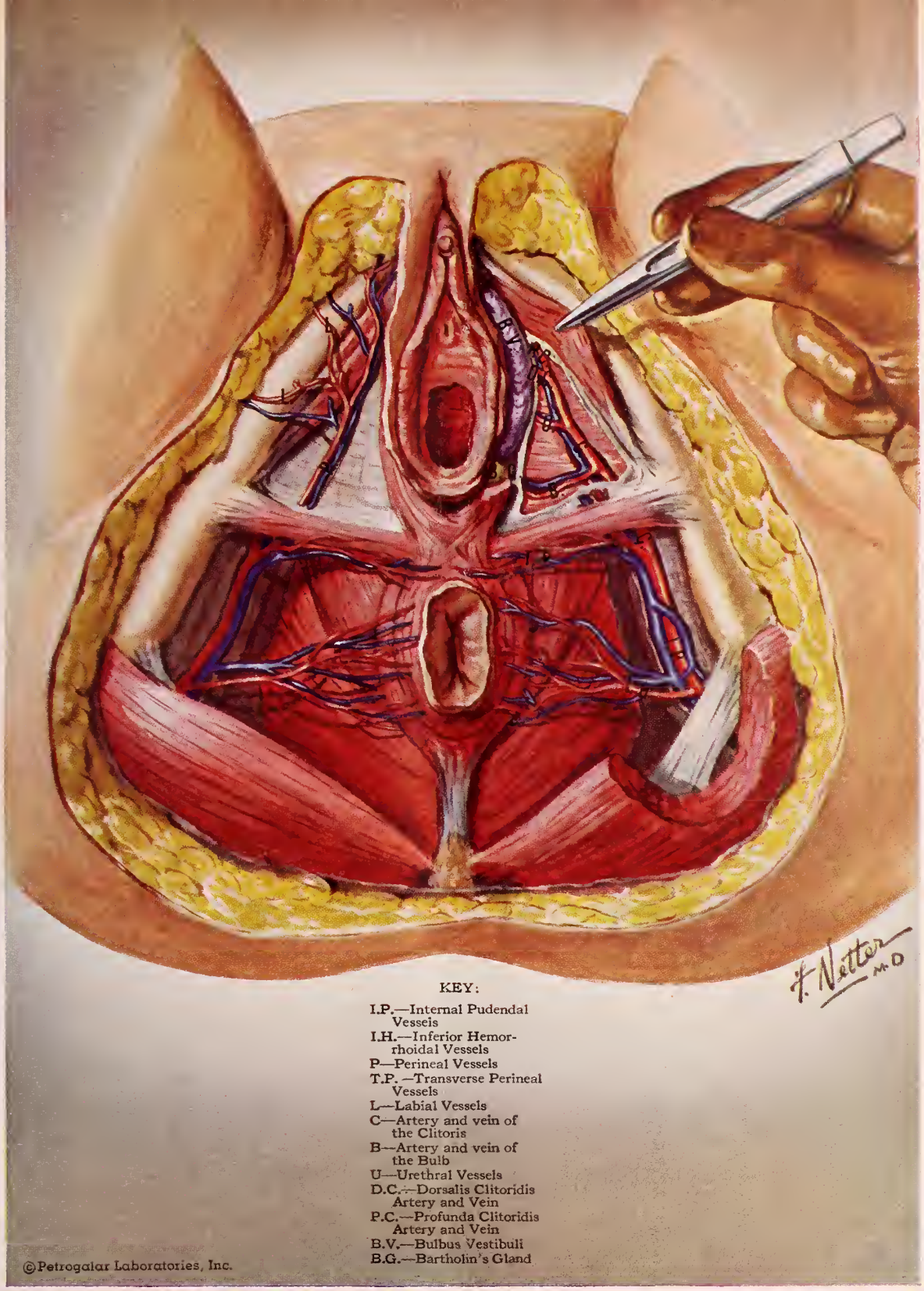
Endoscopic Prostatic Surgery. By Roger W. Barnes, M.S., M.D., F.A.C.S., Professor of Clinical Urology, College of Medical Evangelists; Chief of Urology Service, White Memorial Hospital and Out-Patient Clinic; Senior Attending Surgeon, Los Angeles County Hospital; Consulting Urologist, Glendale Sanitarium Hospital, Glendale, Harriman Jones Clinic Hospital, Long Beach, Southern Pacific Company, Associated Oil Company, Los Angeles Railway Company, and Los Angeles County Farm. Cloth. Pp. 232, with 104 illustrations. St. Louis: The C. V. Mosby Company, 1943.

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The chapters on the anatomy and pathology of the en-

(Continued on Page 17)



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BOOK REVIEWS

(Continued from Page 16)

larged prostate, though brief, stress the basic knowledge needed by the resectionist for an intelligent approach to the operation. The section dealing with the examination of the patient is profusely illustrated, and demonstrates particularly well how the true size of the obstructing gland can be estimated.

The portion of the book devoted to the technique of endoscopic prostatic surgery using the popular Stern-McCarthy electrotome is admirably done. The object of prostatic resection is clearly drawn, yet the pitfalls are stressed and measures designed to circumvent them are clearly depicted, both by the printed word and by excellent illustrations.

Dr. Herman C. Bumpus, Jr., has contributed a chapter on "Punch Prostatectomy," thereby making this monograph quite complete. Litholapaxy and transurethral diverticulotomy are well presented.

Considerable space is devoted to the principles of post-operative care, with particular reference to the importance of the urethral catheter and its care. The closing chapter, dealing with "Results and Sequellae," is an honest and unbiased presentation of the successes as well as the troubles attendant to the procedure. Such an attitude is unusual among the champions of the three schools of prostatic surgery, and is, therefore, very refreshing.

This book can, therefore, be highly recommended to the Urologist, and the reviewer places it alongside Randall's "Pathology of Bladder Neck Obstruction" in the postgraduate student's library.

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TWENTY-FIVE YEARS AGO

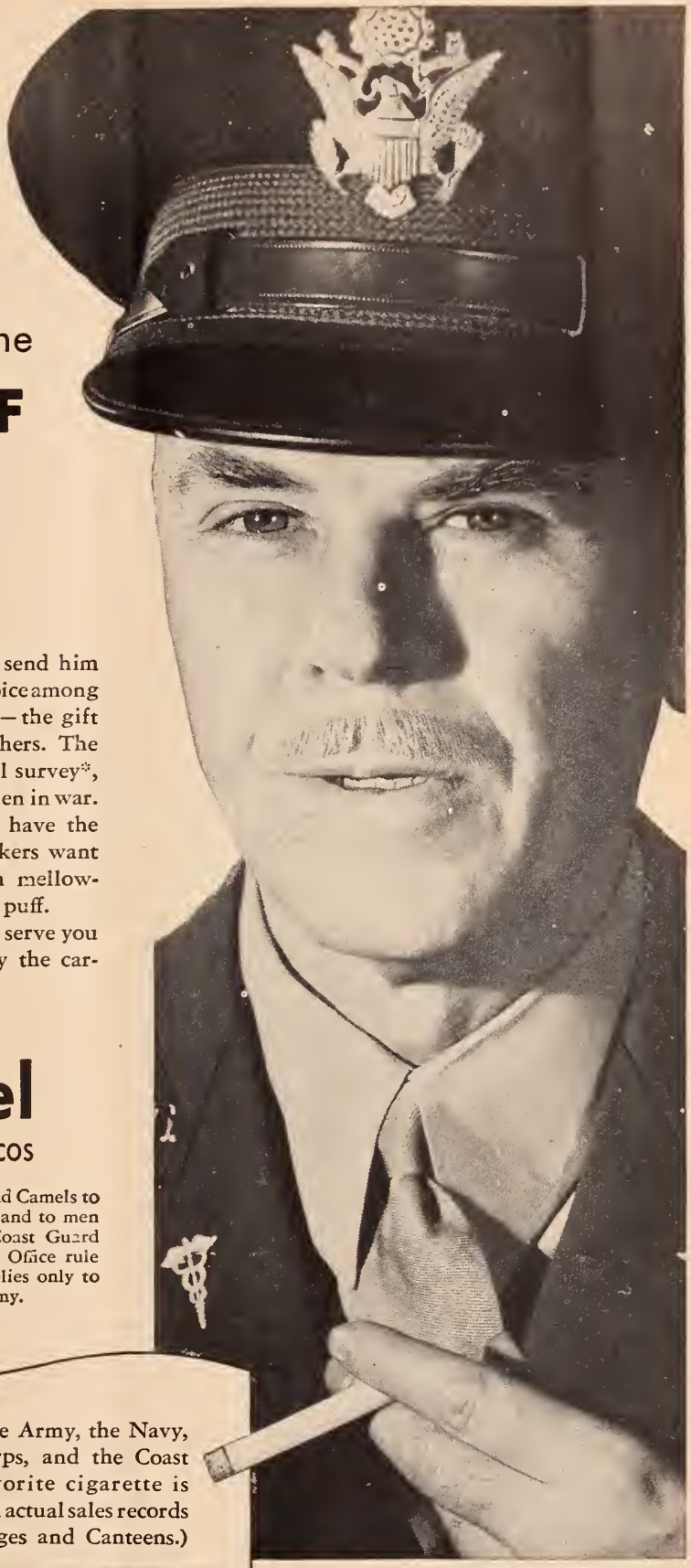
(Continued from Text Page 260)

The movement also includes a survey of institutions caring for the insane for the purpose of determining the best means for improving standards of care among the 200 000 and more sufferers from mental disease in the United States. The prevention and proper care of mental deficiencies is an important feature of the program. The California Society is working through various committees. . . .

Measles Epidemic.—Never before in the history of the State, according to Dr. W. H. Kellogg, Secretary of the California State Board of Health, have measles and German measles been so prevalent. During 1917 there were 23,500 cases of these diseases reported to the State Board of Health, and during January and February of this year no less than 9,000 cases have been reported. While nearly all cases have been of a very mild type, occasionally the disease has appeared in a very severe form. . . .

Distinction Between Medical Defense and Indemnity Defense Fund.—Owing to some existing confusion as to just what the Society does for a member accused of alleged malpractice [Year, 1918], we shall endeavor, in a few words to clarify the matter. One of the purposes of our Society, as defined by the Constitution and By-Laws, is to protect our members from imposition and defend them from groundless charges. . . .

(Continued on Page 20)



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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Spasmodic Vaso-Motor Disturbances of the Respiratory Tract, with Special Reference to Hay Fever," by Grant Selfridge, M.D., San Francisco.—The consensus of opinion put forward within the past two years, as is shown in the literature, seems to indicate definitely that spasmodic vaso-motor disturbances of the nose, including hay fever and asthma likewise, are all anaphylactic or sensitized states, due to proteid poisoning of bacteria, food products, pollens, animal dandruff and animal hair. There also seems to be increasing evidence showing the influence of endocrine glands, especially the adrenals, as well as the sexual glands, thyroid and possibly the pituitary. . . .

From an Article on "Obstetrical Anesthesia," by Caroline B. Palmer, M.D., Lane Hospital, San Francisco.—The intention in the present paper is to consider various means of controlling the suffering incident to childbirth without restriction to the subject of true anesthesia.

That the degree of shock caused by inadequate relief of pain during labor may have far-reaching consequences, has been abundantly proved. Edgar says: "Possibly the majority of the highly-civilized class of women are physically and mentally unfit to suffer an approach to spontaneous labor. Unless guarded from too much suffering, women of this class experience a profound physical and psychic shock in their first confinement, from which some never fully recover. . . .

From an Article on "Some Ocular Defects in Mentally-Retarded Children," by Hans Barkan, M.D., San Francisco, Instructor in Ophthalmology, Stanford University Medical School.—The affections of the eye in childhood are various and, in many instances, peculiar to the eye of the child or young adult—scrofulous Keratitis, some forms of blennorrhea of the sac, and some forms of conjunctivitis; interstitial luetic Keratitis, certain forms of tumor, as glioma, and a certain number of congenital defects, or at least congenital malformations, of certain structures. These latter are found, in my experience at least, very much more frequently in the eyes of mentally-retarded children than in the normal child. Mentally-retarded children, for the purpose of this paper at least, I will consider as being divided into two groups: those whose retardation is due to physical handicap which can be removed—tonsils, adenoids, high-grade myopia or other marked errors of refraction; second, those where, in the absence

(Continued on Page 22)

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

of any marked general or local physical faults, a certain degree of mental retardation is present, evidenced often not only by negative inability to learn as others of the same age do, but also by positive traits; the children are unruly disorderly, disobedient; petty thieving, constant truancy from school, confirmed lying and other evidences of abnormal mental status are common. It is of this second class particularly that I wish to speak. . . .

From an Article on "Congenital Occlusion of the Choanae of the Nose," by H. T. McNaught, M.D., San Francisco.—Congenital occlusion of the choanae of the nose has been recognized since the year 1830 when the condition was seen post-mortem by Otto. It was later first reported as seen in the living by Emmert in 1854. Up to 1904, Schmielglow had collected sixty-four cases from the literature, and in this series it was shown that more women than men were affected, and that when the condition was unilateral, occurred more on the right than left side. Although, so far, only about one hundred cases have been reported, there are reasons for believing that they are of more frequent occurrence than generally supposed. . . .

From an Article on "Kidney Infections in Women," by William E. Stevens, M.D., San Francisco.—Anatomical difference in the female pelvic organs, as well as the physiological changes and the frequent pathological conditions associated with pregnancy and the puerperium, are factors of importance both in the etiology and treatment of renal infections. The shortness of the urethra,

(Continued in Back Advertising Section, Page 25)

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VOLUME 58

APRIL, 1943

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Part I

Annual Session Program

Los Angeles, California, May 2-3, 1943
Seventy-second Annual Session

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Part II

Pre-Convention Program

Reports of Officers and Committees

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WILLIAM R. MOLONY, SR.
President, California Medical Association
1943

SALUTATION FROM PRESIDENT MOLONY

To Members of the California Medical Association—

Greetings:

Last year's annual session at Del Monte was largely attended, although a considerable group had prophesied that but few members would be present, and the meeting, therefore, would be a failure.

During recent months the increasing demand for an all-out war effort has created changes and confusion in our normal plan of living, and the pessimistic "Don't do anything!" has again been heard.

California's place on the Pacific Slope, and throughout the Nation, is well established. The Officers of our Association have wisely decided to maintain the time-honored custom of holding an annual session, but with the sessions streamlined, giving special attention to existing civilian and war needs. The meetings will be held on Sunday and Monday, May 2-3, at the Hotel Biltmore in Los Angeles, when the program will be such that there is every reason for you to attend.

A break in your busy life will be just the thing for you: you will hear, at the general meetings, the best and latest information obtainable, and at the same time renew old acquaintances; and you will shake off that "It-can't-be-done" feeling which is so depressing and works real havoc with our morale.

So plan right now—you and your wife—to come, by auto or by train! Your presence will be evidence that American medicine is on the march, and is not afraid.

Cordially,

WILLIAM R. MOLONY, SR.,
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CALIFORNIA MEDICAL ASSOCIATION



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I

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A. M. Meads	Raymond J. Nutting
Paul Michael	Helen J. Snook
John W. Sherrick	William F. Williams
Delegates	*Alternates*
Butte-Glenn County (1)	
C. E. Plumb	J. O. Chiapella
Contra Costa County (2)	
Alternates	*Delegates*
Kaho Daily	E. R. Guinan
H. D. Neufeld	S. N. Weil
Fresno County (3)	
Alternates	*Delegates*
R. W. Dahlgren	K. D. Leuchauer
E. C. Halley	L. G. Price
G. W. Walker	E. R. Scarboro
Humboldt County (1)	
Alternates	*Delegates*
Joseph F. Walsh	John N. Chain

* For Rosters of Councilors, Standing and Special Committees, and Officers of Component County Medical Societies, see in this issue, on advertising pages 2, 4 and 6. Full roster is omitted here, due to lack of space.

Imperial County (1)

T. E. Bartholomew — Henry Forcher

Inyo-Mono County (1)

Lloyd S. Bambauer — J. Lloyd Mason

Kern County (2)

Frank J. Gundry — J. Headen Inman
Seymour Strongin — Lucille B. May

Kings County (1)

Lionel Sorenson — C. G. Newbecker

Lassen-Plumas-Modoc County (1)

G. S. Martin — W. B. McKnight

Los Angeles County (57)

Eliot Alden — Harry E. Anderson
L. A. Alesen — William Nance Anderson
C. Max Anderson — Roger W. Barnes
John Martin Askey — Paul C. Blaisdell
Samuel Ayres, Jr. — Peter Blong
Wilbur Bailey — Lewis P. Bolander
Conrad J. Baumgartner — Frank J. Breslin
A. Elmer Belt — John MacKenzie Brown
A. A. Blatherwick — John A. Bullis
William C. Boeck — Ernest G. Butt
Karl M. Bonoff — William M. Byers
Howard W. Bosworth — John Frye Chapman
William H. Brownfield — Finnis Gaston Cooper
Donald A. Charnock — John C. Cottrell
Lyle G. Craig — Henry L. Davis
Jay J. Crane — Kenneth S. Davis
John W. Crossan — Howard O. Dennis
William H. Daniel — Robert C. Donham
James C. Doyle — G. R. Dunlevy
John B. Doyle — Franklin Farman
B. R. Dysart — Paul A. Ferrier
Ralph B. Eusden — Arnold L. Gibson
Alvin G. Foord — John D. Gillis
Orrie E. Ghrist — Charles H. Gowan
William M. Gibbs — Lawrence K. Gundrum
Roy W. Hammack — B. H. Hager
Eugene F. Hoffman — Paul M. Hamilton
Carl R. Howson — Arthur Fletcher Hall
Newell Jones — Edward William Hayes
William H. Kiger — Elizabeth Mason Hohl
S. G. Kreinman — Leland G. Hunnicutt
William P. Kroger — E. D. Kremers
Robert W. Langley — Grant H. Lanphere
T. J. Laughlin — L. H. Lee
Leo J. Madsen — Karl Lewis
H. G. McNeil — John P. Lordan
Carl L. Mulfinger — Harold K. Marshall
Thomas Chalmers Myers — Angus C. McDonald
Frank W. Otto — Robert J. Moes
Edward M. Pallette — Paul H. Moore
Edwin F. Patton — Seeley G. Mudd
Paul A. Quaintance — J. C. Negley
Burrell O. Raulston — Edward F. Nippert
Louis J. Regan — John P. Nuttall
E. T. Remmen — William P. Olds
Carl F. Rusche — J. Norman O'Neill
Edward S. Ruth — Carl H. Parker
Raymond Sands — Charles E. Phillips
Harlan Shoemaker — Fenn E. Poole
Kenneth E. Smiley — George S. Sharpe
F. C. Swearingen — Leroy B. Sherry
Roy E. Thomas — Ralph T. Smith
Donald G. Tollefson — Philip Stephens
Robert A. Walker — Raymond W. Swinney
George D. Wells — Richard T. Taylor
Howard F. West — Harold Lincoln Thompson
Harry J. Wiley — William Benbow Thompson

Marin County (1)

Carl W. Clark — John C. W. Taylor

Mendocino-Lake County (1)

Lew Knapp Van Allen — John Henry Lloyd

Merced County (1)

C. C. Fitzgibbons — A. S. Parker

Monterey County (2)

J. B. McCarthy — L. P. Davlin
John C. Sharp — W. H. Farr

Napa County (1)

Dwight H. Murray — R. C. Burkett

Orange County (3)

John D. Ball — L. J. Hannon
M. W. Hollingsworth — Ralph E. Hawes
H. A. Johnston — B. J. Van Doren

Placer-Nevada-Sierra County (1)

William M. Miller — Max Dunievitz

Riverside County (2)

Bon O. Adams — L. E. Brown
Thomas A. Card — Wayne K. Templeton

Sacramento County (4)

Edward S. Babcock — George Briggs
Norris R. Jones — George Browning
F. N. Scatena — Herbert Burden
William J. Van Den Berg — Carl Burkland

San Benito County (1)

Roswell L. Hull — John J. Haruff

San Bernardino County (4)

Walter S. Cherry — John L. Nevin
Ray M. Moose — Emmett L. Tisinger
Robert C. Nichols — Arthur E. Varden
Edward H. Risley — Thomas I. Zirkle

San Diego County (7)

W. L. Garth — D. E. Corbin
W. H. Geistweit, Jr. — C. V. Lindsay
Willard H. Newman — E. M. MacKay
Bryant R. Simpson — L. H. Redelings
John T. Wells — W. Don Rolph
Martha Welpton — J. Weinberger

San Francisco County (22)

H. Glenn Bell — Dorothy W. Atkinson
Frederic C. Bost — Rodney R. Beard
Howard A. Brown — Walter Beckh
Jesse L. Carr — William A. Carroll
L. R. Chandler — Wilbur J. Cox
Lloyd B. Dickey — William C. Deamer
L. Henry Garland — Martin Debenham
Henry Gibbons, III — Henry L. Gardner
John M. Graves — Kenneth D. Gardner
Nelson J. Howard — Leon Goldman
Alson R. Kilgore — Allen T. Hinman
Frederick W. Kroll — Gertrude F. Jones
Stanley H. Mentzer — Charles W. Leach
Robert R. Newell — Salvatore P. Lucia
Charles A. Noble, Jr. — Clayton G. Lyon
George W. Pierce — Mary E. Mathes
J. Marion Read — Horace J. McCorkle
Roland P. Seitz — Earl R. Miller
Sidney J. Shipman — Miriam Miller
Daniel W. Sooy — Gunther W. Nagel
Robert S. Stone — James Ownby, Jr.
Robertson Ward — Beverly Simpson

San Joaquin County (3)

J. Frank Doughty — C. A. Broaddus
Raymond L. Owens — Albert K. Merchant
G. H. Sanderson — J. J. Sippy

San Luis Obispo County (1)

Deon A. Crew — G. D. Kelker

San Mateo County (2)

Logan Gray — C. Benninghoven
William Key — Erma Macomber

Santa Barbara County (3)

Hugh F. Freidell — Harry C. DeVighne
C. W. Henderson — William H. Johnston
Alfred B. Wilcox — Harry L. Schurmeier

Santa Clara County (5)

A. J. Baiocchi — Edward A. Amaral
C. Kelly Canelo — George Hall
Horace Jones — William H. Harder
Dell T. Lundquist — Harry Hoag
John Hunt Shephard — Harold C. Sox

Santa Cruz County (1)

F. P. Shenk — A. J. Sambuck

Shasta County (1)

John E. Kirkpatrick — Guy Leslie Kay

Alternates	*Delegates*
Siskiyou County (1)	
C. C. Dickinson	F. W. Martin
Solano County (1)	
H. Randall Madeley	Arvil E. Chappell
Sonoma County (2)	
Clifford M. Carlson	E. D. Barnett
William N. Markaroff	F. O. Butler
Stanislaus County (1)	
R. S. Hiatt	Hans Hartman
Tehama County (1)	
F. L. Doane	A. H. Meuser
Tulare County (1)	
C. S. Ambrose	Frank R. Guido
Ventura County (2)	
G. C. Coffey	D. G. Clark
F. R. Hendricks*	Charles Smolt
Yolo County (1)	
W. J. Blevins	L. A. Cronan
Yuba-Sutter-Colusa County (1)	
J. A. Duncan	F. P. Wisner

* Deceased

HOUSE OF DELEGATES MEETINGS

40TH ANNUAL SESSION

The House of Delegates will convene in the Music Room (entrance from East-West Galerie) on Sunday, May 2, 1943, at 12:00 noon.*

Speaker, Lowell S. Goin, *Los Angeles*

Vice-Speaker, E. Vincent Askey, *Los Angeles*

Secretary, George H. Kress, *San Francisco*

AGENDA

FIRST MEETING

Sunday, May 2, 1943, at 12:00 o'clock, noon

Order of Business

1. Call to order.
2. Report of Committee on Credentials.
3. Roll call.
4. Announcement and approval of Reference Committees.†
 - *(a)* Committee on Credentials.
 - *(b)* Reference Committee on the Reports of Officers and Standing Committees (Reference Committee No. 1.)
 - *(c)* Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer. Reference Committee No. 2.)
 - *(d)* Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business. (Reference Committee No. 3.)
5. President's address—William R. Molony, Sr.
 Reports:†
6. Report of the Council—Philip K. Gilman, Chairman.
7. Report of the Trustees of the California Medical Association—Philip K. Gilman, President.
8. Report of the Auditing Committee—John W. Cline, Chairman.
9. Report of the Secretary-Treasurer—George H. Kress.

9(a). Report of the Executive Secretary—John Hunton.

10. Report of the Editor, George H. Kress.

10(a). Reports of District Councilors and Councilors-at-large.

11. Report of the Chairman of the Department of Public Relations—Donald Cass.
12. Report of General Counsel—Hartley F. Peart.
13. Reports of Standing and Special Committees:
 - A. Standing Committees.
 - Executive Committee—Henry S. Rogers.
 - Committee on Associated Societies and Technical Groups—John V. Barrow.
 - Committee on Audits—John W. Cline.
 - Committee on Health and Public Instruction—John Ruddock.
 - Committee on History and Obituaries—Morton R. Gibbons, Sr.
 - Committee on Hospitals, Dispensaries, and Clinics—J. Norman O'Neill.
 - Committee on Industrial Practice—Donald Cass.
 - Committee on Medical Defense—Nelson J. Howard.
 - Committee on Medical Economics—Glen F. Cushman.
 - Committee on Medical Education and Medical Institutions—B. O. Raulston.
 - Committee on Membership and Organization—L. A. Alesen.
 - Committee on Postgraduate Activities—G. D. Delprat.
 - Committee on Publications — George W. Walker.
 - Committee on Public Policy and Legislation—Dwight H. Murray.
 - Committee on Scientific Work — George H. Kress.
 - Committee on Public Relations—Donald Cass.
 - Cancer Commission—Harold Brunn.
 - B. Special Committees.
 - Committee on Public Health Education—Frank R. Makinson.
 - Committee on Medical Benevolence—Axcel E. Anderson.
14. Unfinished Business.

 Proposed amendments to Constitution. (See Addendum which appears below.)

 Proposed amendments include:

 (a) Proposed Amendment to Constitution No. 1

 (Concerning Annual Allocation of One Dollar from State Association Dues to C.M.A. Physicians' Benevolence Fund.)
15. Resolutions and New Business.

 (Note: *All resolutions must be in writing, in triplicate, and be handed to the Secretary of the House of Delegates at time of presentation.)*
16. Approval of Minutes.
17. Adjournment of the First Meeting of the House.

* In order to permit the House of Delegates to be called to order promptly, all delegates are requested to register with the Credentials Committee in the foyer section of the Music Room.

† Committees will be announced in programs to appear later.

Excerpt from the California Medical Association By-Laws: Chapter III, Section 6, Paragraphs *(a)* and *(b)*.

"Section 6 *(a)*. Appointment of Committee on Credentials and three Reference Committees.

Prior to or at the beginning of an annual session, the Speaker of the House shall appoint from the members thereof the following committees:

1. Committee on Credentials.
2. Reference Committee on the Reports of Officers and Standing Committees.
3. Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer.
4. Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business.

(b) Membership of Credentials and Reference Committees.

Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

The Reference Committee shall present written reports dealing with and making recommendations on all matters submitted to them. The report of each committee shall be read to its chairman first as a whole, and the House of Delegates shall then act and vote upon the report as a whole or section by section, as it may deem best."

† Reports of officers, standing and special committees appear in full text in the "Pre-Convention Bulletin."

Addenda

Proposed Amendments to the Constitution of the California Medical Association

Procedure to be followed in consideration of proposed amendments as outlined in Article XV, Section 1, is as follows:

ARTICLE XV.—AMENDMENTS

SECTION 1.—*Procedure to Amend Constitution*

Any member of the House of Delegates at any meeting of any regular annual session thereof may present an amendment or amendments to any article or articles or any section or sections of any article or articles of this Constitution.

Such proposed amendment or amendments shall be in writing and shall be filed with the Secretary and shall thereafter be published at least twice in separate issues of the OFFICIAL JOURNAL of this Association prior to the next regular session of the House of Delegates.

At the said next regular session of the House of Delegates, such proposed amendment or amendments shall be submitted to the House of Delegates, for consideration at any meeting of the House of Delegates during that annual session, and if two-thirds of the delegates present and voting vote in favor thereof the same shall be adopted.

* * *

Proposed Amendment Concerning Annual Allocation of One Dollar to C.M.A. Physicians' Benevolence Fund†

(Printed in C. and W. M. in June, 1941, and April, 1942.)

Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association (b) and the same hereby is amended by adding to said Section at the end thereof, the following paragraph: "At least $1 out of the annual dues paid by each member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the by-laws."

* * *

SECOND MEETING

Monday, May 3, at 1:00 p.m. In Music Room, off the East-West Galeria

Order of Business

1. Call to order.
2. Supplemental Report of Credentials Committee.
3. Roll call.
4. Secretary's announcement of Council's selection of place for the 1943 annual session.
5. Election of Officers:
 - *(a)* President-Elect.
 - *(b)* Speaker.
 - *(c)* Vice-Speaker.
 - *(d)* District Councilors**:
 Third District—Harry E. Henderson, Santa Barbara (term expiring).
 Sixth District—John W. Cline, San Francisco (term expiring).
 Ninth District—John W. Green, Vallejo (term expiring).
 - *(e)* Councilors-at-Large:
 (NOTE.—*Each vacancy among Councilors-at-Large, Delegates and Alternates is considered in turn. Each election item is for a specific vacancy.)*
 Dewey R. Powell, Stockton (term expiring).
 Edward B. Dewey, Pasadena (term expiring).
 - *(f)* Delegates to the American Medical Association:

 (For terms: January 1, 1944-December 31, 1945.)

 Incumbents

 - *(a)* Dwight L. Wilbur, San Francisco (term expiring).
 - *(b)* Lyell C. Kinney, San Diego (term expiring).
 - *(c)* Harry H. Wilson, Los Angeles (term expiring).
 - *(d)* Henry S. Rogers, Petaluma (term expiring).
 - *(g)* Alternates to the American Medical Association (Each member elected is alternate to a specific delegate):

 Incumbents

 - *(a)* L. R. Chandler, San Francisco (Alternate to Dwight L. Wilbur).
 - *(b)* Bon O. Adams, Riverside (Alternate to Lyell C. Kinney).
 - *(c)* Roy E. Thomas, Los Angeles (Alternate to Harry H. Wilson).
 - *(d)* Philip K. Gilman, San Francisco (Alternate to Henry S. Rogers).
6. Announcement and Approval of Members of Standing Committees Elected by the Council.
7. Report of Reference Committees:
 - *(a)* Report of Reference Committee on "Reports of Officers and Standing Committees" (Reference Committee No. 1).
 - *(b)* Report of Reference Committee on "Report of the Council and Report of the Secretary-Treasurer" (Reference Committee No. 2).
 - *(c)* Reference Committee on "Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business" (Reference Committee No. 3).
8. Unfinished Business.
9. Presentation of Officers:
 President
 President-Elect
 Speaker
 Vice-Speaker
10. Presentation of Certificate to Retiring President William R. Molony, Sr.
11. Approval of Minutes.
12. Adjournment.

LOWELL S. GOIN, *Speaker*.
GEORGE H. KRESS, *Secretary*.

Important Notice: Re Transportation

Members who are planning to attend the Annual Session should purchase their transportation *now*. Do not delay in this. (Refunders are obtainable, in case transportation and Pullman reservations are cancelled in time.)

** Procedure for nomination of District Councilors is outlined in paragraph 3 of Article VII, Section 1, adopted on May 8, 1940:

The nine district Councilors shall be elected as follows:

Prior to the time set for election of district Councilors, the delegates of each Councilor district for which a councilorship is about to become vacant, shall submit in writing to the Secretary-Treasurer the names of one or more nominees to fill the said vacancy.

The Secretary-Treasurer shall transmit the names of such nominee or nominees so submitted to him to the House of Delegates on or before the time set for the election.

A vote shall be taken by the House of Delegates upon the nominee or nominees so submitted and, in the event that only one nominee has been submitted, the House of Delegates may, by a majority vote, either elect or refuse to elect said nominee.

If the House of Delegates shall reject the sole nominee of the delegates from the councilorship district, concerned, then said delegates must immediately thereafter submit an additional nominee or nominees and the House shall proceed to vote thereon; if there is but one nominee, the House may elect or reject.

If, after such time as the Speaker may allow, delegates within such councilor district fail to submit an additional nominee or nominees, the House of Delegates may then proceed to make nominations from the floor of the House and a vote shall then be taken by the House of Delegates to determine who shall be elected to the vacant councilorship.

All nominees for district councilorships must be members in good standing, residing within the district in which the vacancy exists.

II
PROGRAM: BY DAYS

Special programs, to be distributed at Los Angeles, will give additional information. For meeting room assignments, see bulletin boards, (adjacent to Registration Desk).

First Day: Sunday, May 2, 1943

8:30 a. m. to 5:00 p.m.—Registration (*Galeria — South End*).
9:00 a. m.—First General Session (*Ball Room*).
9:00 a.m. to 6:00 p. m.—Military Exhibits (*East - West Galeria*).
9:00 a. m. to 11:30 noon—Military and Medical Films (*Music Room*).
12:00 noon—First Meeting of House of Delegates (*Music Room*).
2:00 p. m.—Second General Session (*Ball Room*).
7:00 p. m.—Dinner to the President (*Biltmore Bowl*).

Second Day: Monday, May 3, 1943

8:30 a. m. to 5:00 p. m.—Registration (*Galeria — South End*).
9:00 a. m.—Third General Session (*Ball Room*).
9:00 a. m. to 6:00 p. m.—Military Exhibits (*East-West Galeria*).
9:00 a. m. to 12:00 noon—Military and Medical Films (*Music Room*).
1:00 p. m.—Second Meeting of House of Delegates (*Music Room*).
2:00 p. m.—Section Meetings (*Conference Rooms via North Galeria*).

* * *

C.M.A. Council will hold its first meeting on Saturday, May 1, 1943, and will meet on Sunday and Monday.

Film exhibits will be given on Sunday-Monday mornings (in Music Room), and perhaps on Sunday afternoon in Logan and Bryan Room (East-West Galeria, near Grand Avenue entrance).

For announcements of affiliated organizations and other notices, consult bulletin boards at registration desk (south end of main North-South Galeria).

"Western Association of Industrial Physicians and Surgeons" will hold its third annual session, commencing on Thursday, April 29, through Saturday, May 1, 1943.

"California Heart Association" will convene in annual session on Saturday, May 1, 1943.

LOS ANGELES

Some Highlights in Its History

Los Angeles is the second oldest city officially founded in California and the third oldest in rank as an early habitation center. San Diego Mission, founded in 1769, was the earliest civilized development in California. From San Diego, Gaspar de Portola and Juan Crespi marched north and began developments in the Monterey area in 1770. San Gabriel Mission, near Pasadena, was founded September 8, 1771. Just ten years later on September 4, 1781, *"El Pueblo de Nuestra Senora la Reina de Los Angeles de Porciuncula"* (now Los Angeles) was officially founded by the third Spanish Governor to California, Felipe de Neve.

Before the founding of Los Angeles, about 300 Indians, called Yang-na, lived in the Los Angeles area, unmolested and unmindful of their inevitable doom.

During many years following the founding of Los Angeles nothing of note happened. The country was left to the explorers and that arduous colonizer, the missionary.

All life in the Pacific Southwest in those days revolved about the missions, which was primarily communal among the Indians, who were disciplined by soldier guards. Agriculture and livestock were the principal industries. Commerce, as it is known today, was unknown. Lethargy, indifference and stagnation, from a world point of view, were the order of the day in the early Spanish era of Los Angeles.

In 1822, news arrived from Mexico that these one-time Spanish colonies were free and independent. However, little difference was noted at "El Pueblo de Los Angeles" where Mexican authority followed, when Spanish domination ended. It was really only a change in name.

The beginning of the American period cannot properly be traced to a single date or incident. The Treaty of Cahuenga, the signing of which took place at Cahuenga Pass, near Hollywood, between Andres Pico and John C. Fremont, January 13, 1847, ended hostilities in California and made clear the claims of the United States which were settled at Hidalgo, Mexico, the following year. The events leading to these treaties are of great importance in early Los Angeles history.

Subsequent incidents which precipitated actual trouble in California were mainly sponsored by filibusterers in the persons of the "Gringos" who had pushed their way across the continent to enter this promised land. It was simply a matter of conquest. Events, leading to actual occupation, followed in quick succession after the penetration of "Eastern" people had begun. At Sonoma, William B. Ide, proclaimed his short-lived Republic under the Bear Flag. On July 7, 1846, Commander John D. Sloat hesitatingly raised the Stars and Stripes over Monterey, then turned over the command to Commodore Stockton, who, with Fremont, proceeded south, where Captain Gillespie was placed in charge of the Los Angeles garrison on August 13th—the day the City of Los Angeles was taken.

But this garrison of fifty soldiers left at Los Angeles was insufficient to insure what otherwise might have been a bloodless conquest of the region.

Then, from out of the desert, came a new figure of importance, General Stephen W. Kearny, marching with his victorious army from the Texan campaign. At the border he had been met by Kit Carson with news of earlier victories in California. Because of this good news, Kearny sent back to the "States" all but 121 of his men.

Marching across the hot barren desert, his weary-worn soldiers little expected the surprise attack from the elated Angelenos at San Pasqual, where thirty-seven Americans were killed and wounded in a bloody battle. Luckily, however, with the aid of reënforcements sent by Stockton, Kearny with his remaining force reached San Diego where plans were made to march on Los Angeles—the last Mexican stronghold in California.

A long tedious march to Los Angeles concluded the campaign; little resistance being made by the Californians. In January, 1847, Kearny entered the city after a skirmish at La Mesa, where hardly a shot was fired. Two days later Fremont entered Los Angeles from the north after having signed the treaty of Cahuenga which brought the city under a new government, the United States of America.

At the time California became a part of the Union, the slave question was at a high pitch. The political powers of the country were endeavoring to balance votes and, because of this, California remained a territory until 1850, when Statehood was finally achieved. During these years armies of gold seekers came to the Coast and caused a vicious element to drift to Los Angeles.

(Continued on Page 203)

SCIENTIFIC ASSEMBLY—GENERAL AND SECTION MEETINGS

III

GENERAL MEETINGS

For index of speakers, see page 179

All General Meetings will be held in the Ball Room (at the south end of the North-South Galeria)

Section Meetings (with exception of E. E. N. and T.) will be held in Conference Rooms (near Grand Avenue entrance of East-West Galeria; use stairway to mezzanine floor).

First General Meeting

Sunday Morning, May 2, 1943, at 9:00 a. m.

Presiding

Henry S. Rogers, *Past President*
William R. Molony, Sr., *President*

(1)

Invocation—Right Reverend Monsignor Thomas J. O'Dwyer.

(2)

Address of Welcome—E. Vincent Askey, M. D., President of the Los Angeles County Medical Association.

(3)

Greetings from the Woman's Auxiliary—Mrs. F. G. Lindemulder, President of the Woman's Auxiliary to the California Medical Association.

(4)

Address of President—William R. Molony, Sr., M. D., Los Angeles, President of the California Medical Association.

(5)

Progress of the Program of Procurement and Assignment Service for Physicians in California—Harold A. Fletcher, M. D., San Francisco, Chairman, and Edward M. Pallette, M. D., Los Angeles, Vice-Chairman.

(6)

Report of Committee on Public Policy and Legislation—Dwight H. Murray, M. D., Napa, Chairman.

(7)

Burns—Captain F. R. Hook, MC, U.S.N., U. S. Naval Hospital, Oakland.

(8)

California Physicians' Service: Its Current Activities—E. Vincent Askey, M. D., Los Angeles.

(9)

Wartime Community Health Problems in Oregon—John H. Fizgibbon, M. D., Portland, Oregon.

✤

Second General Meeting

Sunday Afternoon, May 2, 1943, at 1:30 p. m.

Presiding: William R. Molony, Sr., President
F. L. Reichert, Chairman, Section on Surgery

(10)

Voluntary Nonprofit Health Plans—John R. Mannix, Director, Michigan Hospital Service, Detroit, Michigan.

(11)

Disposition of Sub-standard Military Personnel—Colonel William P. Corr, M.C., Director of Medical Division and Chief of Medical Service, Hoff General Hospital, Santa Barbara.

(12)

Detailed Methods of Diagnosis and Therapy in Acute Nutritive Failure—Tom D. Spies, M. D., University of Cincinnati, College of Medicine.

(13)

Some Medical Problems in Wartime Industry—William A. Sawyer, M. D., Eastman Kodak Company, Rochester, New York.

(14)

War Anesthesia in the South Pacific—Lt. Comdr. Edwin Hal Kelley, MC, U.S.N., U. S. Naval Hospital, San Diego.

(15)

Tropical Diseases—Lt. Comdr. Richard F. McLaughlin, MC, U.S.N.R., U. S. Naval Hospital, Oakland.

(16)

California Council of Civilian Defense—Morton R. Gibbons, Sr., M. D., San Francisco.

(17)

Proctoscopic Color Movies—Lt. Comdr. J. Peerman Nesselrod, MC, U.S.N.R., U. S. Naval Hospital, San Diego.

✤

Third General Meeting

Monday Morning, May 3, 1943, at 9:00 a. m.

Presiding: William R. Molony, Sr., President
Garnett Cheney, Chairman, Section on Medicine

(18)

Some Phases of High Altitude Physiology—Major Leonard Hines, Medical Corps, Army of the United States, Station Hospital, Santa Ana Army Air Base, Santa Ana.

(19)

Experience with Large Scale Sulfadiazine Administration—Major Norman Nixon, Medical Corps, Army of the United States, Station Hospital, Santa Ana Army Air Base, Santa Ana.

(20)

An "Information Please"—Guest Speaker, Tom D. Spies, College of Medicine, University of Cincinnati, will answer questions on Nutritive Problems. Questions should be in writing.

(21)

Health Control in Welding Work—Philip Drinker, Sc.D., Chief Health Consultant, Division of Shipyard Labor Relations, United States Maritime Commission, Washington, D. C.

(22)

Penetrating Wounds of the Abdomen—Major Ray B. McCarty, Medical Corps, Army of the United States, Hoff General Hospital, Santa Barbara.

(23)

Malaria—Lt. Comdr. P. F. Metildi, MC, U.S.N.R., U. S. Naval Hospital, San Diego.

REMEMBER:
(1) Purchase Transportation *Now*.
(2) Make Hotel Reservation.
(SEE ELSEWHERE FOR SCHEDULES AND RATES)

IV

SECTION MEETINGS

For index of speakers, see page 179

SCIENTIFIC SECTION PROGRAMS

(Numbers in parenthesis after each section indicate sequence reference numbers of papers read in each section.)

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REGISTRATION INFORMATION

Registration and Information. Registration and information desks are located in the North-South Galeria, adjacent to the ramp auto entrance. All members, guests and visitors are requested to register immediately on arrival. Registration secretaries will be on duty from 8:30 a. m. to 5 p. m.

Annual Session Program. Copies of complete session proceedings, showing times and places of all meetings, are available at the registration desk.

Military Films. Military films, supplied through the courtesy of the Regional Officers of the Medical Corps of Army and Navy, will be on display in the Music Room (off East-West Galeria) on Sunday and Monday mornings. Display limited to members and their guests. Your badge will serve as a ticket of admission.

Suggestions and Criticisms. Members are invited to present suggestions and criticisms to the officers and committees through the registration desk. These suggestions may be made to refer to either this session or future annual sessions and will be given full consideration by those concerned.

Rules Regarding Papers and Discussions at Annual Sessions. Section Officers, Essayists, and members taking part in discussions are requested to read the rules adopted by the C.M.A. Council and the C.M.A. Committee on Scientific Work, relating to papers and discussions. These will appear in the pocket programs, to be distributed at the Registration Desk. Proper and impersonal observance of these rules by all concerned, will make for more successful meetings.

Whom to Consult. The following activities are under the supervision of Dr. Kress, Association Secretary:
(a) General Meeting Programs
(b) Section Meeting Programs
(c) Equipment of Meeting Rooms
(d) Military Exhibits
(e) Military Films

Registration Desks are under the supervision of the Executive Secretary, Mr. Hunton.

Messages for Dr. Kress and Mr. Hunton should be left at the Registration Desk, when open. (At other times, as per notices on the bulletin board of the registration desk.)

Pre-Convention Bulletin. Annual reports of officers, councilors and committees appear in the April issue of CALIFORNIA AND WESTERN MEDICINE. Additional copies of these reports will be made available to delegates and alternates for their study either at the registration desk or at the first meeting of the House of Delegates.

Badges. Badges will be issued at the registration desk. Separate types of badges will be issued for members, delegates, alternates, officers, exhibitors, and section officers. Please request the proper type of badge on registering.

Tickets for "Dinner to the President." For information, see under Entertainment. Tickets will be on sale at Registration Desk. Special reservations available for parties of eight or more.

Woman's Auxiliary. Headquarters for the Auxiliary will be in Suite 333-335. Registration Desk also available for information.

Guests and Visitors. All guests and visitors are requested to register and to secure a badge and program. All general meetings and scientific meetings are open to visitors and guests so registered. There is no charge for registration.

Bulletin Boards. Consult bulletin boards in the Galeria for announcements of special events. A diagram of meeting places of scientific sections will also be found on these bulletin boards.

Military Exhibits. Exhibits this year will be limited to displays by the Army and Navy. East-West Galeria, opposite entrance from downstairs lobby, has been allocated for such exhibits.

Technical Exhibits. Because this year's Annual Session is a two- instead of a four-day session, it was not deemed advisable to display technical or commercial exhibits.

I

GENERAL MEDICINE SECTION

Meeting Room: Foyer to Banquet Room, off East-West Galeria, adjacent to Auto Ramp

GARNET CHENEY, M. D., *Chairman*
490 Post Street, San Francisco

MAST WOLFSON, M. D., *Secretary*
215 Franklin Street, Monterey

FRED B. CLARKE, M. D., *Assistant Secretary*
505 Professional Building, Long Beach

Monday, May 3, 1:30 p. m.

Paper No. 24:
Chairman's Address—Garnet Cheney, M. D., 490 Post Street, San Francisco.

Paper No. 25:
Some of the Newer Concepts in the Etiology and Treatment of Diabetes Mellitus—W. D. Sansum, M. D., Cottage Hospital, Santa Barbara.

Most workers agree that a too high blood sugar causes existing diabetes to become progressively worse. A too high blood sugar after meals may be the most important factor in precipitating the disease in those who are predisposed. More important statistically, it may be the basic cause in many of the very large overweight group. More attention must be paid to the blood sugar.

Discussion by Clare Shepardson, M. D., San Francisco, William H. Grishaw, M. D., Los Angeles, and James W. Sherrill, M. D., La Jolla.

Paper No. 26:
Exophthalmos in Patients with Various Types of Goiter—Mayo H. Soley, M. D., University of California Hospital, San Francisco.

The eyes of patients with nontoxic goiter are no more prominent than the eyes of normal persons. Patients with toxic nodular goiter may have exophthal-

mos, but their eyes are not as prominent as those of patients with toxic diffuse goiters. Patients with toxic diffuse goiters have significantly more prominent eyes than do normal people and following sub-total thyroidectomy, exophthalmos increases in over one-half these patients.

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Business Recess

Business Meeting and Election of Officers

Paper No. 27:

Some Aspects of the Relation of Gastro-Intestinal Diseases to Anginal Pain—Hilmar O. Koefod M. D., Santa Barbara.

The possible relationship of acute coronary insufficiency to lesions of the gastro-intestinal tract discussed. Case reports given.

Discussion by William Kerr, M. D., San Francisco, Fletcher Taylor, M. D., Oakland, and John Sampson, M. D., San Francisco.

Paper No. 28:

Atypical Coronary Disease in Young People—Major Joseph Weinstein, Medical Corps, Army of the United States, Fort Ord.

Discussion of atypical coronary disease, recent and old, and a study of ten cases, 20 to 37 years of age, the majority Negroes, observed at Station Hospital, Fort Ord, California, showing characteristic ECG variations and a clinical course suggestive of an atypical type of coronary disease with myocardial involvement.

Discussion by John Sampson, M. D., San Francisco, and J. Marion Read, M. D., San Francisco.

Paper No. 29:

Arthritis and Allied Conditions in an Army General Hospital—Captain Edward W. Boland Medical Corps, Army of the United States, Hoff General Hospital, Santa Barbara.



II

GENERAL SURGERY SECTION

Meeting Room: Banquet Room, South End of East-West Galeria, adjacent to Auto Ramp

F. L. Reichert, M. D., *Chairman*
Lane Hospital, San Francisco

J. Norton Nichols, M. D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

Leon Goldman, M. D., *Assistant Secretary*
University of California Hospital, San Francisco

Monday, May 3, 1:30 p. m.

Paper No. 30:

Chairman's Address—F. L. Reichert, M. D., Lane Hospital, San Francisco.

Paper No. 31:

Soft Tissue Complications of Fractures of the Leg—Lt. Colonel A. B. Sirbu, Major M. J. Murphy, Captain A. S. White, Medical Corps, Army of the United States, Fort Ord.

A critical analysis of complications associated with and following fractures of the tibia and fibula, with special reference to arterial spasm. Cast reports of spastic arterial occlusion. Volkmann's ischemic contracture and localized gangrene of the tibilis anticus muscle are presented. The prevention and treatment of these serious complications are discussed and their importance in War Surgery is stressed.

Paper No. 32:

The Evaluation of Thyroid Function by Blood Iodine Fractionation—E. J. Joergenson, M. D., 1200 N. State Street, Los Angeles, A. L. Chaney, Ph.D., and H. J. Hoxie, M. D., 312 N. Boyle Avenue, Los Angeles.

The division of blood iodine into organic and inorganic fractions has been studied in one thousand cases; about one-half were thyroid. Blood iodine determination has been studied in relation to severity and type of disease, in preoperative management, and in measuring improvement in patients treated by surgery and radiation.

Discussion by A. L. Chaney, Ph.D., Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 33:

Gastric Resection for Peptic Ulcer—John W. Cline, 490 Post Street, San Francisco.

A review of the experience with gastric resection for gastric, duodenal and gastrojejunal ulcers and gastrojejunocolic fistulae during the past four years on the Stanford Surgical Service of the San Francisco Hospital, with a discussion of indications for operation, operative procedures, postoperative care and results based upon this experience.

Discussion by Verne C. Hunt, M. D., Los Angeles, Thomas F. Mullen, M. D., San Francisco, and L. A. Alesen, M. D., Los Angeles.

Paper No. 34:

Cholangiograms During Operation—Stanley H. Mentzer, M. D., 450 Sutter Street, San Francisco.

The method for making diagnostic studies of the bile ducts by aspiration and injection of opaque substances through needle puncture wounds is outlined. This method permits accurate diagnosis without surgical section and consequent closure of the bile ducts or of intubation. The technique of the use of various substances are discussed and illustrative cases are selected for discussion from a series of 168 consecutive case reports.

Discussion by Leon Goldman, M. D., San Francisco.

Paper No. 35:

Traumatic Injuries of the Chest—H. E. Schiffbauer, M. D., Suite 1005, Brockman Building, Los Angeles.

Review of Blast Injuries of the Chest. Treatment of injuries of ribs and sternum. Early treatment of Esophageal and Diaphragmatic injuries. Treatment of gunshot wounds of the lungs—the necessity of early removal of blood from the pleural cavity. Discussion of contused and penetrating injuries of the heart with emphasis on heart tamponade.

Discussion by Leo Eloesser, M. D., San Francisco, and John Jones, M. D., Los Angeles.

Military Exhibits and Films

Do not fail to see the military exhibits and films.

For these we are indebted to the Medical Corps of the Army and Navy.

III

OBSTETRICS AND GYNECOLOGY SECTION

Meeting Room: Conference Room No. 1, on Mezzanine Floor, off North Galeria

NORMAN H. WILLIAMS, M. D., *Chairman*
409 N. Camden Drive, Beverly Hills

PHILIP H. ARNOT, M. D., *Vice-Chairman*
490 Post Street, San Francisco

ROY E. FALLAS, M. D., *Secretary*
1930 Wilshire Boulevard, Los Angeles

Monday, May 3, 1:30 p. m.

Paper No. 36:

Recent Advances in Treatment of Pelvic Peritonitis—George E. Judd, M. D., 1930 Wilshire Boulevard, Los Angeles.

A report of the study of fatal results of pelvic infections. Suggested improvements in treatment based on the pathological physiology of peritonitis.

Discussion by J. C. McDermott, Los Angeles.

Paper No. 37:

Chairman's Address—Norman H. Williams, M. D., 409 North Camden Drive, Beverly Hills.

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Business Recess

Business Meeting and Election of Officers

Paper No. 38:

The Significance of the Vaginal Smear Method in the Early Diagnosis of Uterine Cancer—Herbert F. Traut, M. D., University of California, San Francisco.

For the past three years, Dr. Papanicoloau and Dr. Traut have developed a method at the Cornell Medical School whereby it has been possible for them to recognize well-established lesions of the cervix and fundus of the uterus, and also those in their incipiency by means of vaginal smears.

Discussion by Ludwig A. Emge, San Francisco, and Herman Zeiler, M. D., Los Angeles.

Paper No. 39:

The Influence of War Work on Gynecological Problems—William C. Bradbury, M. D., 1137 Second Street, Santa Monica, and Charles Benjamin S. Evans, M. D., 3000 Ocean Park Avenue, Santa Monica.

Certain types of work in the war industries are producing an increase of gynecological complaints of the women workers. A comparative study is made of different groups and the results analyzed.

Paper No. 40:

The Rh Factor in Obstetrics—Philip A. Reynolds, M. D., 200 West Third Street, Los Angeles.

A history of the development of the Rh factor and its significance as an etiological factor in erythroblastosis fetalis and atypical transfusion reactions. The presentation of a new theory concerning the Rh factor as a cause of certain anemias of pregnancy.

Discussion by Roy W. Hammack, M. D., Los Angeles.

CALIFORNIA STATE BOARD OF PUBLIC HEALTH

Physicians are invited to meet with the California State Board of Public Health, and submit suggestions or queries. See bulletin board for time and place of meeting.

IV

EYE, EAR, NOSE, AND THROAT SECTION

Meeting Room: Logan and Bryan Room, off North-South Galeria, adjacent to Grand Avenue Entrance

MAJOR FERRIS L. ARNOLD (M.C.), *Chairman*
Div. Surg. Hq. 7th Div., Fort Ord

WALTER R. CRANE, M. D., *Vice-Chairman*
727 W. Seventh Street, Los Angeles

GEORGE MCCLURE, M. D., Secretary
411 Thirtieth Street, Oakland

Section Aides:

Monday, May 3, 1:30 p. m.

Paper No. 41:

Chairman's Address—Major Ferris L. Arnold, Medical Corps, Army of the United States.

Paper No. 42:

The Nonsurgical Treatment of Glaucoma—M. N. Beigelman, M. D., 1930 Wilshire Boulevard, Los Angeles.

The relative value of various autonomic drugs in congestive, simple and secondary glaucoma is analyzed and the limitations in their use are established. Recent advances in osmotic therapy and radiation therapy are reviewed in the light of personal experience. The necessity of early surgical interference in refractory cases is stressed.

Discussion by C. H. Albaugh, M. D., Los Angeles, and Orwyn Ellis, M. D., Los Angeles.

Paper No. 43:

Epidemic Infections of the Eye in Present War Areas—Charles Weiss, Ph.D., M. D., Mount Zion Hospital, San Francisco.

A survey of epidemic and endemic contagious diseases prevalent in North Africa and Pacific Islands to which our armed forces may be exposed. Emphasis will be placed upon bacteriological and immunological diagnosis. Lantern slides illustrating findings in infections due to bacteria, viruses, rickettsia and spirochaetes will be shown.

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Business Recess

Business Meeting and Election of Officers

Paper No. 44:

Facial Fractures—Howard P. House, M. D., 511 South Bonnie Brae, Los Angeles.

In a world geared all out for war, a review of the treatment of facial fractures is indeed timely.

An illustrative discussion of the treatment of facial fractures will be presented. Emphasis will be placed on fractures which involve the sinuses; their respective immediate and delayed treatment by the Oto-laryngologist will be reviewed.

Discussion by E. F. Tholen, M. D., Los Angeles.

Paper No. 45:

The Allergic Nose—Ben R. Dysart, M. D., 65 North Madison Avenue, Pasadena.

The more frequent use of nasal smears is urged as an easy, quick, reliable method of making the differential diagnosis between the allergic nose and the infected nose. Eosinophiles are always present in nasal mucous in allergy. Several mistreated cases reported. Technique of making tests discussed.

Discussion by Victor Goodhill, M. D., Los Angeles.

Paper No. 46:

Acute Laryngo-Tracheo-Bronchitis—Harold Owens, M. D., 1215 N. Cummings Street, Los Angeles.

This paper deals with the treatment of acute laryngo-tracheo-bronchitis summarized from the results of treating a mild epidemic of twenty-four

cases during a one and one-half month period at the Los Angeles Children's Hospital. A sample case history will be given in conclusion to illustrate the therapy utilized.

Discussion by Shirley D. Wimmer, M. D., Los Angeles.

V

ANESTHESIOLOGY SECTION

Meeting Room: Conference Room No. 6, on Mezzanine Floor, off North Galeria

Ernest H. Warnock, M. D., *Chairman*
1136 West Sixth Street, Los Angeles
Evelyn H. Case, M. D., *Secretary*
374 Thirty-fourth Street, Oakland

Monday, May 3, 1:30 p. m.

Paper No. 47:
Chairman's Address — Ernest H. Warnock, M. D., 1136 West Sixth Street, Los Angeles.

Paper No. 48:
The Responsibility of Flexibility of Anesthesia—Seth Sensiba, M. D., 930 Fourteenth Street, Santa Monica.

Anesthesia like all other branches of medicine is becoming more and more a physician's responsibility, primarily because the safety of the patient, economic considerations and requirements of the surgeon demand it.

An anesthetic should be flexible enough to satisfy these requirements and to do so necessarily enters the field of diagnosis and treatment.

Paper No. 49:
Refrigeration Anesthesia for Amputation—Kathryn C. Redus, M. D., 753 N. Sunset Boulevard, Temple City.

This is an account of Refrigeration Anesthetic technique as practiced at the Los Angeles County General Hospital with report of cases.

Business Recess

Business Meeting and Election of Officers

Paper No. 50:
Pentothal Sodium in Anesthesia—Dirk E. Stegeman, M. D., 5103 Biloxi Avenue, North Hollywood.

Some clinical experiences with the use of Pentothal Sodium in Anesthesia, especially as to its use in children who are to undergo operations on the face or any of its component parts.

Discussion by Bruce Anderson, M. D., Oakland, and Hubert Hathaway, M. D., San Francisco.

Paper No. 51:
The Mechanism of Action of Sympathomimetic Amines—Clinton H. Thienes, M. D., 210 N. Central Avenue, Glendale.

A discussion of the actions of sympathomimetic amines on normal and denervated organs and on enzymes, and a comparison of effects on the central nervous system and on peripheral structures. Fundamentally most of these compounds seem to produce their effects through influencing the rate of destruction of epinephrine, sympathin and acetylcholine.

Symposium on Spinal Anesthesia

Paper No. 52:
Spinal Anesthetic Agents and Methods Usually Employed at the University of Oregon Medical School Hospitals—John H. Hutton, M. D., 3181 S. W. Marquam Hill Road, Portland.

Procaine and Pontocaine are frequently combined in order to obtain anesthesia lasting more than an hour, sometimes two hours. Dosage, dilution, and site of injection are outlined for various surgical procedures on lower extremities, perineum, and for laparotomies involving the lower and upper abdomen. Spinal anesthesia is intentionally combined with inhalation anesthesia for upper abdominal operations.

Paper No. 53:
Procaine-Nupercaine Anesthesia as Practiced at the Los Angeles County General Hospital — Adele Schmidt, M. D., 1200 N. State Street, Los Angeles.

A critical study of surgical cases at Los Angeles County General Hospital in which procaine and nupercaine were used for prolonged spinal anesthesia.

Paper No. 54:
Spinal Anesthesia with Crystalline Pontocain—W. LeRoy Garth, M. D., Medico-Dental Building, San Diego.

The use of crystalline pontocain in some 600 consecutive administrations, with the average dosage, dilution and placement. The author concludes, from the results obtained, that this drug when mixed with the indicated quantities of spinal fluid, is a safe and desirable agent, comparing most favorably with procain, and in addition affording approximately twice the available anesthetic time.

Paper No. 55:
Fractional Spinal Anesthesia—E. H. Bolze, M. D., 516 Sutter Street, San Francisco.

Discussion of technique of Fractional Spinal Anesthesia. Indications—contra-indications. Its use in a program of selective anesthetic procedures. Report of the use of this procedure in 75 cases requiring prolonged anesthesia.

Discussion of the "Spinal Anesthesia" papers by Dell T. Lundquist, M. D., Palo Alto.

General Discussion.

VI

DERMATOLOGY AND SYPHILOLOGY SECTION

Meeting Room: Conference Room No. 4, on Mezzanine Floor, off North Galeria

Merlin T.-R. Maynard, M. D., *Chairman*
241 E. Santa Clara Street, San Jose

Philip King Allen, M. D., *Vice-Chairman*
233 A Street, San Diego

Frederick G. Novy, Jr., M. D., *Secretary*
411 Thirtieth Street, Oakland

Section Aides:
Nelson Paul Anderson, M. D., Los Angeles
Louis F. Wilhelm, M. D., Los Angeles

Monday, May 3, 1:30 p. m.

Paper No. 56:
Chairman's Address—A Functional Concept in Dermatological Management—Merlin T.-R. Maynard, M. D., 241 E. Santa Clara Street, San Jose.

Business Recess

Business Meeting and Election of Officers

Paper No. 57:

The Intensive Treatment of Early Syphilis with Mapharsen Combined with Fever Therapy—Norman N. Epstein, M. D., 450 Sutter Street, San Francisco, and Rees B. Rees, M. D., 1230 Seventh Avenue, San Francisco.

A preliminary report is presented on a method of treatmcnt of early syphilis in which intcnsive Mapharsen therapy is combined with fever therapy. The technique, therapeutic results are discussed. Two cases of arsenic resistant early syphilis treated with this method are reported.

Discussion by Stanley Owen Chambers, M. D., Los Angeles, and Philip King Allen, M. D., San Diego.

Paper No. 58:

Bullous Lichen Sclerosis et Atrophicus—C. Russell Anderson, M. D., 1930 Wilshire Boulevard, Los Angeles.

A sixty-year-old woman presents bullous lesions of lichen sclerosis et atrophicus. The relation to bullous scyleroderma is discussed.

Discussion by Harry J. Templeton, M. D., Oakland, and Kendal P. Frost, M. D., Los Angeles.

Paper No. 59:

Pemphigus—William Henry Goeckerman, M. D., 727 W. Seventh Street, Los Angeles.

An experience with three cases treated with acetarsone.

Discussion by Nelson Paul Anderson, M. D., Los Angeles, and Maximilian Ernest Obermayer, M. D., Los Angeles.

Paper No. 60:

Dermatological Experiences at a U. S. Naval Hospital—Frederick G. Novy, Jr., M. D., Lt. Comdr., MC, V(S) U.S.N.R., U. S. Naval Hospital, Oakland.

This paper will consist of a brief résumé of the different types of dermatologic and venereal dieases encountered at the U. S. Naval Hospital, Oakland.

Discussion by Hiram D. Newton, Lt. Comdr., MC, V(S), U.S.N.R., U. S. Naval Hospital, San Diego.

Paper No. 61:

Aspects of Lymphopathia Venereum—Richard A. Koch, M. D., Chief, Division of Venereal Diseases, Department of Public Health, City and County of San Francisco, San Francisco.

The paper is proposed to present information as to the method of diagnosis, history, medical diagnosis, distribution, incidence, and public health significance of the disease. This will include information as to the recognition of the disease, source of infection, mode of transmission, period of communicability, prevalence, and public health methods of control.

Discussion by Malcolm H. Merrill, M. D., Berkeley, and Lieutenant Ervin Epstein, Medical Corps, Army of the United States, Torney General Hospital, Palm Springs.

ANNUAL SESSION PROGRAMS: OUTLINES OF ADDRESSES

Conforming to custom of former years, special programs will be given to all who register. These will contain outlines of papers that are missing in the "Pre-Convention Bulletin."

VII
INDUSTRIAL MEDICINE AND SURGERY SECTION

Meeting Room: Conference Room No. 7, on Mezzanine Floor, off North Galeria

JOHN D. BALL, M. D., *Chairman*
414 Spurgeon Building, Santa Ana

LEONARD B. BARNARD, M. D., *Vice-Chairman*
2939 Summit Street, Oakland

FLOYD F. THURBER, M. D., *Secretary*
6065 Hollywod Boulevard, Los Angeles

Section Aides:
JEROME W. SHILLING, M. D., Los Angeles
CLAYTON G. STADFIELD, M. D., Los Angeles

Monday, May 3, 1:30 p. m.

Paper No. 62:

Chairman's Address—John D. Ball, M. D., 414 Spurgeon Building, Santa Ana.

Paper No. 63:

Venereal Disease Control in Industry—Richard A. Koch, M. D., Chief Division of Venereal Diseases, City Clinics, San Francisco.

Will cover methods of case finding through education and serologic survey at plant, final diagnosis and reference to proper treatment agency according to social standards of individual; value to Industry and relation to general venereal disease control program.

Paper No. 64:

Reduction of Fracture of Tibial Tuberosity by Clamp—William L. Weber, M. D., Chief Surgeon Pacific Electric Railway, Los Angeles.

Will discuss fracture of the Tibial plateau with disruption of the joint from displacement of the tuberosity; reduction by compression with Carpenter's clamp and immobilization in plaster. Experience shows results are superior to open operation. Illustration with lantern slides.

Paper No. 65:

Unusual Findings in Pre-Empoyment Examinations at Douglas Aircraft Corporation—Wendel S. Keate, M. D., Medical Department, Douglas Aircraft, Los Angeles.

This paper will discuss not only physical findings but laboratory findings as well, including chest x-rays and will present unusual trends in the findings in mass examinations of applicants for employment.

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Business Recess

Business Meetings and Election of Officers

Paper No. 66:

Fracture of the Femur in the Adult—Joseph D. Peluso, M. D., 315 W. Ninth Street, Los Angeles.

This discussion will be confined to fractures of the femur in the adult and will include fractures of the shaft as well as intertrochanteric fractures. It will cover internal fixation of intertrochanteric fractures with postoperative care and treatment. It will attempt to point out the different methods of treatment covering the skeletal traction method, traction by skin and internal fixation. Mention will be made of the Stader splint and Roger-Anderson well-leg traction. Purpose of the paper is to point out that there is no specific treatment for fractured femurs. Treatment must be applied to the type of fracture. At least three cases will be presented showing the final result although three different methods were used.

Paper No. 67:

Examination for Placement of Workers with Physical Defects—George D. Wells, M. D., 4317 Downey Road, Los Angeles.

This paper will show the necessity for placement of such workers in the present war effort. It will discuss the special examination of the defect for its proper evaluation and the translation of these factors for the employer. It will not only approach this subject in relation to new workers but will cover special examination for replacement of workers following injuries with permanent effects.

VIII

NEUROPSYCHIATRY SECTION

Meeting Room: Conference Room No. 9, on Mezzanine Floor, off North Galeria

KARL OTTO VON HAGEN, M. D., *Chairman*
727 West Seventh Street, Los Angeles

JACOB KASANIN, M. D., *Secretary*
2200 Post Street, San Francisco

Section Aides:

GLENN E. MYERS, M. D., Los Angeles
DOUGLAS CAMPBELL, M. D., San Francisco

Monday, May 3, 1:30 p. m.

SPECIAL SYMPOSIUM ON MILITARY NEUROPSYCHIATRY

Paper No. 68:

War and Its Influence upon Civilian Psychiatry—H. E. Chamberlain, M. D., 616 K Street, Sacramento.

The present relationship between psychiatry and medicine and the status of the practice of each as based upon wartime regulations are briefly outlined. Data of an inferential nature are presented. Three issues made acute by war and which have a direct bearing upon civilian morale and the anticipated post-war integration of the armed personnel, are discussed with emphasis given to medical practice, supplemented by psychiatric interpretation and a combined therapy jointly assumed. Factors inherent in health and welfare and the marginal features of both tend to limit the effectiveness of therapy which either medical practice or psychiatric procedure independently follow. Six groupings of such factors and features are submitted as illustrative material In the form of practical recommendations, the conclusion stresses fundamental changes in the concept of medical practice and participation in social security and welfare planning.

Paper No. 69:

Psychiatric Problems in a Military Hospital—Major Andrew I. Rosenberger, and Captain Robert E. Wyers, Medical Corps, Army of the United States, Hoff General Hospital, Santa Barbara.

This paper includes a survey of the psychiatric work done during 1942 at the Hoff General Hospital, Santa Barbara, California. A statistical summary, emphasizing the more common disorders, is presented. The mental mechanism of the psychoneurotic seen in the military service is discussed. The handling of the psychiatric problem according to Army Regulations is reviewed and some of the more frequent problems in the disposition of cases are related. Reasons for the unsuitability for Army work of the average psychoneurotic are given. Suggestions are made, from a psychiatric standpoint, as to how induction of obviously unsuitable personnel may be avoided. An approximation is made of the cost of diagnosis, care and disposition of the average psychiatric case.

Paper No. 70:

Chairman's Address — Discussion of the Psychoses Following Childbirth—Karl Otto von Hagen, M. D., 727 West Seventh Street, Los Angeles.

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Business Recess

Business Meeting and Election of Officers

Paper No. 71:

The Neuropsychiatric Service of a Naval Hospital—Lt. Comdr. A. H. Held, MC, Lt. Comdr. C. W Tidd, MC, U.S.N.R., U. S. Naval Hospital, San Diego.

In the first part of this paper the training and indoctrination of the Naval Psychiatrist is briefly outlined. The places in the Naval Medical Program in which psychiatry functions are mentioned; in particular, in the elimination of the unfit in the training stations and afterwards, and second in the hospital, base and advanced base. The function of the psychiatric service in the base hospital is described in some detail. This includes a discussion of the psychiatrically unfit; types of cases encountered as well as an account of the ways in which these cases are disposed of.

In the second part of the paper certain factors related to the appearance of mental illness and emotional maladjustment in the naval service are discussed. Included in this discussion are factors of Naval Discipline, closer scrutiny, changes in living habits, danger or anticipation of danger, and personality type. The ways in which these factors affect the individual are examined. Certain material from various cases is cited to illustrate the foregoing and finally an attempt is made to draw some conclusions regarding general psychiatric problems in the naval service.

Paper No. 72:

Psychiatry at an Air Base Station Hospital—Lieutenant B. H. L. Gartshore, Medical Corps, Army of the United States, Air Base Station Hospital, Pendleton, Oregon.

The kinds and quantities of psychiatric patients at a station hospital of moderate size are discussed The kinds of patients seen are like those of a civilian general psychiatric practice anywhere; there are some minor differences, in the army as compared to civilian life, in the quantities of each kind, especially in the constitutional psychopathies and the mental deficiencies. The disposition of each kind of type of patient is traced out, and it is made clear that for the majority of psychiatric patients the disposition must be discharge from the army by one technique or another. The psychoneuroses seen are described in general terms. They constitute the principal problem, in numbers of patients seen, in time taken for treatment, and also in requiring the greatest judgment in determining the disposition. Treatment of all the various types of patients is discussed briefly, and the five major obstacles to successful psychotherapy of the psychoneuroses in the army are outlined. Brief mention is made of some of the more striking psychiatric manifestations seen.

Paper No. 73:

Neuropsychiatry in a Replacement Training Center—Major Julius Schreber, Medical Corps, Army of the United States, A.A.R.T.C., Camp Callan.

The various steps and procedures are described that take place from the date of induction until the newly-inducted trainee is finally assigned to a Basic Training Unit in a Replacement Training Center The initial Intelligence Tests, the processing, and the type of environment in which the new soldier finds himself are set forth in detail.

The function of the Special Training Units is described and the type of work that it performs is given in detail. The use of enlisted personnel as psychiatric interviewers is also described. Then follows an analysis of 2,033 neuropsychiatric examinations that were made in the 8-month period from June 1, 1942, through January 31, 1943.

The question of psychiatric therapy in a Replacement Training Center is discussed. The rôle of the psychiatrist in the morale program of the Camp is set forth in detail. The mental hygiene lectures which he gives to the officers and the soldiers are outlined.

General discussion opened by Glenn E. Myers, M. D., Los Angeles.

IX

PATHOLOGY AND BACTERIOLOGY SECTION

Meeting Room: Conference Room No. 3, on Mezzanine Floor, off North Galeria

Jesse L. Carr, M. D., *Chairman*
University of California Hospital, San Francisco

A. M. Moody, M. D., *Vice-Chairman*
631 O'Farrell Street, San Francisco

R. H. Osborne, M. D., *Secretary*
312 North Boyle Avenue, Los Angeles

James B. McNaught, M. D., *Assistant Secretary*
2398 Sacramento Street, San Francisco

Section Aides:
Carroll S. Small, M. D., Loma Linda
David A. Wood, M. D., San Francisco

Monday, May 3, 1:30 p. m.

Paper No. 74:

Chairman's Address—Jesse L. Carr, M.D., University of California Hospital, San Francisco.

Correlation of Prothrombin Time, Vitamin A, Cholesterol-Cephalin, and Phosphatase Tests in Experimentally Produced Liver Disease.

Paper No. 75:

Intra-Group Hemolytic Transfusion Reactions Due to the Rh Factor—Roy W. Hammack, M. D., 637 S. Westlake Avenue, Los Angeles.

Many unexplained hemolytic transfusion reactions have been reported. The discovery of the Rh factor and the importance of the Rh factor in explanation of reactions is discussed. Report of three cases presented.

Discussion by Alvin G. Foord, M. D., Pasadena, A. M. Moody, M. D., San Francisco, and Charles Weiss, M. D., San Francisco.

Paper No. 76:

Untoward Effects of Sulfonamide Therapy—Ralph E. Homann, M. D., University of Southern California, School of Medicine, 3551 University Avenue, Los Angeles.

This is a preliminary report of a series of cases which, following sulfathiazole therapy, presented focal necrosis in various organs at post-mortem examination. A description of the lesions found with a summary of the chief clinical findings will be given. (Lantern slides.)

Discussion by David G. Mason, M. D., San Francisco.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 77:

Gargoylism, Report of a Case in a Young Adult—Reuben Straus, M. D., and Reuben Merliss, M. D., Cedars of Lebanon Hospital, 4833 Fountain Avenue, Los Angeles.

Gargolyism, a disease characterized by a typical deformity of the patient, is seldom diagnosed due to its rarity and unfamiliarity. It is of unknown etiology and pathogenesis, usually of insidious onset in infancy and with a chronic course. The case to be reported is that of a person older than previously studied, in which extensive clinical and pathological studies were done.

Discussion by Francis Scott Smyth, M. D., San Francisco.

Paper No. 78:

Primary Carçinoma of the Liver—David A. Wood, M. D., Stanford University School of Medicine, 2398 Sacramento Street, San Francisco.

This is a clinical and pathologic study of 49 cases of primary carcinoma of the liver, of which 96 per cent were in males. Nine were under 40 years of age and one was prenatal. Ninety-two per cent were liver cell carcinomas and 8 per cent originated in the intrahepatic bile ducts. Cirrhosis was coexistent in 54 per cent of the cases. The incidence of extrahepatic metastases was low. (Lantern slides.)

Discussion by Newton Evans, M. D., Los Angeles.

X

PEDIATRIC SECTION

Meeting Room: Conference Room No. 2, on Mezzanine Floor, off North Galeria

E. H. Christopherson, M. D., *Chairman*
420 Walnut Avenue, San Diego

William C. Deamer, M. D., *Secretary*
University of California Hospital, San Francisco

Howard R. Cooder, M. D., *Assistant Secretary*
3875 Wilshire Boulevard, Los Angeles

Monday, May 3, 1:30 p. m.

Paper No. 79:

Chairman's Address—E. H. Christopherson, M. D., 420 Walnut Avenue, San Diego.

Paper No. 80:

The Significance of Pediatrics—Joseph Brennemann, M. D., 4614 Sunset Boulevard, Los Angeles.

This talk attempts to point out for the benefit of pediatrists and others what pediatrics is contributing

at present, and proposes to contribute in the near future to the physical and general welfare of babies, of children and of adolescents.

Paper No. 81:

Causes of Sudden Death in Childhood and Infancy—Rea F. Chittenden, M. D., 4222 Lankershim Boulevard, North Hollywood.

This paper is divided into four sections: the first is concerned with the physiology of the infant, i.e., the physical factors that predispose to sudden death; the second portion lists pathological processes which may account for sudden death; the third portion is devoted to discussion of actual reported causes of sudden fatality, and the fourth section is a series of case résumés. The material presented is from the records of pediatrists and pathologists, as well as from recently published material.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 82:

The Present Status of Poliomyelitis—Norman Nelson, M. D., 1724 Camino Palmero, Los Angeles.

There are three questions on poliomyelitis which every pediatrist would like answered. First—how does the virus spread? Second—how is it diagnosed? Third—how is it treated? This discussion presents a critical analysis of the various reported methods of spread, also some of the difficulties of diagnosis, and also a brief review of the Kenny method of treatment, and of nerve crushing.

Paper No. 83:

Rheumtaic Fever and Rheumatic Heart Disease in Los Angeles. A Hospital Study—David B. Davis, M. D., 2629 Brighton Way, Beverly Hills, and Sidney Rosin, M. D., 637 Ridgley Drive, Los Angeles.

Children with rheumatic disease, to the number of 137, admitted to the Los Angeles County General Hospital were carefully studied. The following conclusions were derived: There was the same relatively low incidence as in other subtropical regions. No seasonal variation was noted. Familial incidence was negligible. Temperature, rainfall and relative humidity had no influence. Chorea is less frequent than in other cities, chiefly eastern, of the same size.

Paper No. 84:

The Rh Factor and Its Rôle in the Anemias of the Newborn—Charles Weiss, M. D., Chief of Clinical Laboratories, Mount Zion Hospital, San Francisco.

Case histories and lantern slides will be used to illustrate experience in the study and management of anemias of the newborn, including erythroblastosis fetalis. The nature and rôle of the Rh antigen and antibody in these diseases will be discussed.

WHY NO SCIENTIFIC OR TECHNICAL EXHIBITS AT THIS SESSION

Because the coming 72nd annual conference of members of the California Medical Association will be a brief, two-day streamlined session, the Committee on Scientific Work deemed it inadvisable to ask California colleagues to present scientific exhibits. Thanks are expressed to those who were willing to coöperate with scientific displays or films.

Because of present conditions, the Committee on Scientific Work decided to place emphasis on military medicine.

XI

RADIOLOGY SECTION

Meeting Room: Conference Room No. 8, on Mezzanine Floor, off North Galeria

RAY A. CARTER, M. D., *Chairman*
1200 N. State Street, Los Angeles

ROY W. JOHNSON, M. D., *Secretary*
1407 S. Hope Street, Los Angeles

Section Aides:
WALTER STILSON, M. D., Los Angeles

Monday, May 3, 1:30 p.m.

Paper No. 85:

Chairman's Address—Ray A. Carter, M. D., 1200 N. State Street, Los Angeles.

Paper No. 86:

The Roentgenographic Interpretation of Bone Tumors—Ian Macdonald, M. D., and John W. Budd, M. D., 1407 South Hope Street, Los Angeles.

A study of the growth patterns of tumors of bone, and of the stromal responses evoked by their presence. Illustrative roentgenograms and photomicrographs, chiefly of connective tissue sarcomata primary in bone (osteosarcoma, chondrosarcoma, fibrosarcoma), their comparative radiographic appearance, and the fallacy of "typical" roentgenograms. Based on material from the Registry of Bone Sarcoma.

Discussion by Kenneth Davis, M. D., Los Angeles.

Paper No. 87:

Intra and Para-Sellar Calcification and its Roentgenologic Significance—Lt. Comdr. John D. Camp, MC, U.S.N.R., U. S. Naval Hospital, Corona.

The roentgenologic demonstration of calcification within or about the sella turcica may be of varying clinical significance. The location, size, shape and density of the calcium shadows is of great importance in appraising their significance and in distinguishing neoplastic disease from other conditions of lesser importance. In many lesions the calcium is arranged in a more or less characteristic manner so that the roentgenologist may predict the nature of the underlying condition with a high degree of accuracy. The differential diagnosis of such lesions and other nonpathologic conditions that may be confounded with them will be shown by means of representative roentgenograms.

Discussion by Cyril Courville, M. D., Los Angeles.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 88:

Low Back Pain Resulting from Apophyseal Subluxation and Fractures of the Articular Facets—Lt. Comdr. Wendell G. Scott, MC, U.S.N.R., U. S. Naval Air Station, San Diego.

Pertinent anatomic and physiologic aspects of these structures are illustrated by lantern slides. The wide range of normal variation which they exhibit will be demonstrated so that they will not be confused with pathologic changes of clinical significance. The requirements for apophyseal subluxation are presented and the condition demonstrated as a cause of low back pain. Fractures of the articular facets are not infrequent and should always be searched for in-patients with back injuries.

Discussion by Wilbur Bailey, M. D., Los Angeles.

Paper No. 89:

Diagnosis and Treatment of Cancer of the Skin and Lip, Demonstrated by Colored Moving Pictures—Henry J. Ullmann, M. D., 1520 Chapala, Santa Barbara.

Motion pictures, largely in color of skin cancers and lesions resembling or suggesting skin cancers. Results of treatment.

Presentation of cancer cases after the manner of the Radiological Section of the Cancer Commission sessions of previous years.

Note: The annual meeting of the Pacific Roentgen Society will not be held.

XII

UROLOGY SECTION

Meeting Room: Conference Room No. 5, on Mezzanine Floor, off North Galeria

Wirt B. Dakin, M. D., *Chairman*
802 Pacific Mutual Building, Los Angeles
Arno G. Folte, M. D., *Secretary*
870 Market Street, San Francisco

Section Aides:

R. Theodore Bergman, M. D., Los Angeles
Tracy O. Powell, M. D., Los Angeles

Monday, May 3, 1:30 p. m.

Paper No. 90:

Chairman's Address—Post-War Medical Practice—Wirt B. Dakin, M. D., 802 Pacific Mutual Building, Los Angeles.

Facts and figures to help reduce expenses and improve professional efficiency. Office plans and furnishings drawn to scale. This Paper should help doctors reëstablish their practice after the war, and can benefit *any* doctor that has an office.

Discussion by George G. Reinle, M. D., Oakland.

Paper No. 91:

Cutaneous Ureterostomy—Miles Griffin, M. D., 411 Thirtieth Street, Oakland.

Cutaneous ureterostomy is a valuable procedure which has not enjoyed the popularity it deserves because of false impressions regarding the inconvenience of taking care of the diversion of urine. The indications for the procedure, features in technique and suggestions regarding the after care of the patient are discussed. Report of cases.

Discussion by Adolph A. Kutzmann, M. D., Los Angeles.

Paper No. 92:

Calcified Aneurism of the Renal Artery—Commander J. P. Brady, MC, U.S.N., and Commander J. S. Hanten, MC, U.S.N.R., U. S. Naval Hospital, Mare Island.

Report of a case of calcified true aneurism of the left renal artery with a discussion as to treatment and a heretofore unpublished suggestion as an aid to diagnosis.

Discussion by Thomas E. Gibson, M. D., San Francisco.

Paper No. 93:

Primary Neoplasms of the Ureter—Roger W. Barnes, M. D., 1216 Wilshire Boulevard, Los Angeles.

Every case of hematuria, especially if a hydronephrosis is found, should have adequate uretero-grams, which must be studied carefully to avoid overlooking a ureteral tumor. Complete uretero nephrectomy is the treatment. Six new cases are reported.

Discussion by Carl F. Rusche, M. D., Hollywood.

Paper No. 94:

Estrogens (Stilbestrol) Uses in Urology—James Ownby, Jr., M. D., 490 Post Street, San Francisco.

Paper to consider Stilbestrol versus castration; Stilbestrol and castration in the treatment of cancer of the prostate, as well as the dangers of the use of Stilbestrol over a long period of time and in large quantities. Also the use of Stilbestrol in the treatment of benign hypertrophy of the prostate.

Discussion by Hermon C. Bumpus, M. D., Pasadena.

✣

Business Recess

Business Meeting and Election of Officers

Paper No. 95:

Bilateral Nephrolithiasis in Horseshoe Kidney—Franklin Farman, M. D., 727 West Seventh Street, Los Angeles.

Anomalies in upper urinary tract are more commonly observed than in any other system of body. When bilateral nephrolithiasis occurs anomaly of kidney should be suspected. Surgical risk increased by anomaly, lowered kidney function, and infection. Case report and motion picture demonstration technique of pyelolithotomy and nephrostomy in horseshoe kidney.

Discussion by Albert J. Scholl, M. D., Los Angeles.

Paper No. 96:

A Study of Syphilis in the Male Relative to Fertility—Lewis Michelson, M. D., 490 Post Street, San Francisco.

Fifty cases of men who have had syphilis are analyzed. From this study, devoted particularly to characteristics of the semen, the author concludes that syphilis, when correctly treated, rarely affects the fertility of the male. Charts and lantern slides.

Discussion by Donald A. Charnock, M. D., Los Angeles.

Open Forum (if time allows).

Thanks to Section Officers

This year, with some Section Officers in military service, extra work fell on those who remained. Until several months ago, it was not possible to decide whether an annual session could be held in the year, 1943. The lateness of the decision added to the program difficulties.

A glance at the Section programs reveals how well the Section Secretaries have done their work.

For this coöperation, the C.M.A. Committee on Scientific Work (which is also responsible for the programs of the general meetings) expresses its appreciation and thanks.

(Signed) The C.M.A. Committee on Scientific Work,
Fletcher B. Taylor, Oakland,
J. Homer Woolsey, Woodland,
Howard F. West, Los Angeles,
Mast Wolfson, Monterey
J. Norton Nichols, Los Angeles,
George H. Kress, San Francisco,
Chairman.

V
MILITARY EXHIBITS

East-West Galeria (Galeria running to Grand Ave.)

Scientific Exhibits such as have been on display in previous years will not be presented at the 72nd Annual Session. Their place is taken by military displays put on through the courtesy of Medical Officers who are on service in the United States Army and Navy. These exhibits will be in charge of deputized military personnel.

A descriptive outline of their nature will appear in the annual session programs. The exhibits will portray the manner in which medical service is rendered at the battle fronts.

Other exhibits will show the work of Procurement Divisions of the Armed Services.

The California Council of Medical Defense will also present an exhibit, as will several colleagues whose displays concern military medicine.

VI
FILMS: MILITARY, MEDICAL, SURGICAL, AND PUBLIC HEALTH

Music Room, off East-West Galeria

Films will be presented in the Music Room (off the East-West Galeria, near junction with main North-South Galeria).

Films will be shown during the morning hours and, unless otherwise announced, a different film will start on each half-hour, commencing at 9 a.m. and continuing until the noon hour.

Time of presentation of films will be posted on bulletin boards at the entrance of the Music Room. A revised list of films will appear in the Convention programs, to be distributed at Los Angeles.

The California Medical Association is indebted to Officers of the Army and Navy for the military films which will be displayed in the Music Room on Sunday and Monday mornings. If arrangements can be made, they will be shown also, in the Logan-Bryan room, at the end of the north East-West Galeria, adjacent to the Grand Avenue entrance.

VII
ROSTER OF TECHNICAL EXHIBITORS

As elsewhere announced, no technical or commercial exhibits will be on display at the 72nd Annual Session. The brief, two-day conference, and transportation difficulties, especially under existing conditions, made necessary the postponement of such displays for more favorable conditions in the future.

VIII
ENTERTAINMENT

Consult bulletin board in main Galeria (by registration desk), for information.

President's Dinner.—Hotel Biltmore, Sunday, May 2, at 7:30 p.m. in Biltmore Bowl (entrance by way of South Galeria, near ramp). Reservations must be made in advance, as capacity of dining room is limited. Reservations can be made for single tickets and for tables of six or more persons. Make reservations at Registration Desk.

The Local Committee on Arrangements will present an entertainment program at this dinner at 9:30 p.m. sharp. During the floor show the dining room doors will be closed and table service will stop. For these reasons it is imperative that those attending the dinner should be in the dining room promptly at 8:00 p.m.

Dancing.—Dancing (in the Biltmore Bowl) to Hotel Biltmore's orchestra will follow the Dinner to the President.

IX
TRANSPORTATION INFORMATION

Reduced-rate convention transportation is *not* available this year.

Because of heavy passenger traffic it is important that transportation and pullman reservations (going and returning) be secured immediately by all who contemplate attendance at the Annual Session, to be held in Los Angeles, Sunday, May 2—Monday, May 3, 1943.

This precaution is particularly called to the attention of program participants and general and section officers.

Do not delay in this. Otherwise you may be disappointed. Under existing conditions, one day's delay may mean securing or not securing reservations.

Note. The "Lark" on the Southern Pacific leaves Los Angeles at 9:00 p.m., arriving at 9:00 a.m. in San Francisco, and vice versa. All meetings will probably adjourn by 6:00 p.m., on Monday, May 3rd.

Transportation Information

Following schedules are subject to change. (Verify them.)

Southern Pacific

FROM SAN FRANCISCO

Name of Train	*Number*	*Leave San Francisco*	*Arrive Los Angeles*
	I. *Coast Route*		
Lark	76	9:00 p.m.	9:00 a.m.
Daylight	98	8:15 a.m.	6:00 p.m.
Coaster	70	6:30 p.m.	8:30 a.m.
	II. *Valley Route*		
Owl	26	6:00 p.m.	8:35 a.m.
San Joaquin Daylight	53	7:30 a.m.	8:00 a.m.

FROM OAKLAND

		Leave Oakland	Arrive Los Angeles
Owl	26	6:32 p. m.	8:35 a. m.
Lark	74-76	8:00 p. m.	9:00 a. m.

FROM SACRAMENTO

		Leave Sacramento	Arrive Los Angeles
West Coast	15-60	8:00 p. m.	9:10 a. m.

* * *

United Airlines

United Airlines at the present time has a schedule showing nine flights daily between San Francisco and Los Angeles.

Hours of departure from San Francisco are as follows: 3:05 a.m., 6:45 a.m., 8:30 a.m., 11:00 a.m., 2:00 p.m., 4:00 p.m., 4:45 p.m., 6:15 p.m., and 8:30 p.m.

Hours of arrival in Los Angeles of the above airships are: 5:46 a.m., 9:15 a.m., 10:30 a.m., 1.38 p.m., 4:00 p.m., 6:10 p.m., 7:26 p.m., 8:25 p.m., and 10:40 p.m.

Los Angeles departure schedule to San Francisco follows: 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:45 p.m., 2:15 p.m., 5:00 p.m., 6:45 p.m., 8:00 p.m., and 11:30 p.m.

The round trip fare between San Francisco and Los Angeles is $37.90—one way $18.95.

Reservations should be made in ample time. The San Francisco office of United Airlines is 400 Post Street.

United Airlines also flies airships between Los Angeles and San Diego, the round trip being $12.00—one way $6.00.

* * *

Santa Fe Railroad

San Francisco The Santa Fe at the present time has a schedule of 9 trains daily between San Francisco-Oakland and Los Angeles. (All San Francisco trains transfer to bus, at Bakersfield.)

Hours of departure from San Francisco are as follolws: 9:00 a.m. (Streamliner), 3:00 p.m., 6:00 p.m. (Streamliner), and 11:30 p.m.

Hours of arrival in Los Angeles of the above trains are: 7:05 p.m., 4:10 a.m., 4:10 a.m., and 1:20 p.m.

San Diego The Santa Fe has 5 trains and 11 buses between Los Angeles and San Diego daily, the round trip being $3.03 by either train or bus, one way by bus $1.98 and by train $2.18.

X

HOTELS

The official headquarters of the next annual session will be the *Hotel Biltmore*, 518 South Olive Street, (Olive, between Fifth and Sixth Streets), Los Angeles. Because of the prospective attendance, the facilities of other hotels may also be used.

All requests for reservations must be sent to the hotels direct. In writing, it is well to state the number in the party, date of arrival, date of departure, nature of accommodations desired (single room, double room, double bed, twin beds, bath).

For additional information, inquire at California Medical Association registration desk (located on the East-West Galeria).

LOS ANGELES HOTELS: WITH TELEPHONE NUMBERS

A list of some hotels in Los Angeles within easy distance of the Biltmore.

Hotels	*Telephones*
Alexandria Hotel, 210 W. Fifth St.	(MAdison 2741)
Ambassador Hotel, 3400 Wilshire Blvd.	(DRexel 7011)
BILTMORE HOTEL*, 515 S. Olive	(MIchigan 1011)
Carlton Hotel, 529 S. Figueroa St.	(MIchigan 6571)
Chapman Park Hotel, 615 S. Alexandria Ave.	(FItzroy 1181)
Clark Hotel, 426 S. Hill St.	(MIchigan 4121)
Gates Hotel, 830 W. Sixth St.	(TRinity 3931)
Hayward Hotel, 206 W. Sixth St.	(MIchigan 5151)
Mayfair Hotel, 1256 W. Seventh St.	(FItzroy 4161)
Mayflower Hotel, 535 S. Grand Ave.	(MIchigan 1331)
Monarch Hotel, 905 W. Fifth St.	(MIchigan 7311)
San Carlos Hotel, 507 W. Fifth St.	(MUtual 2291)
Savoy Hotel, 601 W. Sixth St.	(MAdison 1411)
Stillwell Hotel, 838 S. Grand Ave.	(TRinity 1151)
Town House, 639 S. Commonwealth Ave.	(EXposition 1234)
William Penn Hotel, 2208 W. Eighth St.	(EXposition 3181)

* Headquarters Hotel.

* * *

Biltmore Hotel: Headquarters Hotel
515 S. Olive (MIchigan 1011)
Mr. Alvin Knocke, Assistant Manager
(In charge of reservations)

Single rooms	$5.00, $5.50, $6.00, $6.50 and $7.00
Double rooms	$7.00, $7.50, $8.00, $8.50 and $9.00
Suites	$12.00, $15.00, $20.00

All rooms in the Biltmore have individual private baths, and in the case of the doubles, twin or double beds are optional.

' ' '

AMBASSADOR HOTEL
3400 Wilshire Blvd. (DRexel 7011)
Mr. J. E. Benton, Manager

Single room with bath, one person	$ 5.00
Double room with bath, two persons	8.00
Twin beds	15.00
Two single rooms, bath between, two persons, each	8.00
Two double rooms, bath between, four persons, each	15.00

' ' '

ALEXANDRIA HOTEL
210 W. Fifth St. (MAdison 2741)
Mr. Clayton V. Smith, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

' ' '

CHAPMAN PARK HOTEL
615 S. Alexandria Ave. (FItzroy 1181)
Mr. Harry S. Ward, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

' ' '

CLARK HOTEL
426 S. Hill St. (MIchigan 4121)
Mr. Beckett, Manager

Single room with bath, one person	$3.00
Double room with bath, two persons	4.00

' ' '

GATES HOTEL
830 W. Sixth St. (TRinity 3931)
Mr. Vernon Peck, Manager

Single room without bath, one person	$1.50
Double room without bath, two persons, each	1.50
Single room with bath, one person	3.00
Double room with bath, two persons	4.00
Two single rooms, bath between, two persons, each	4.00
Two double rooms, bath between, four persons, each	4.00

HAYWARD HOTEL

206 W. Sixth St. (MIchigan 5151)

Mr. Russell Wagner, Manager

Single room without bath, one person	$2.00
Double room without bath, two persons, each	2.50
Single room with bath, one person	2.50
Double room with bath, two persons	3.00
Two single rooms, bath between, two persons, each	3.50

MAYFAIR HOTEL

1256 W. Seventh St. (FItzroy 4161)

Mr. H. H. Hasslinger, Manager

Single room with bath, one person	$2.75
Double room with bath, two persons	3.30

MAYFLOWER HOTEL

535 S. Grand Ave. (MIchigan 1331)

Mr. J. B. Huesman, Manager

Single room with bath, one person	$2.75
Double room with bath, two persons	3.85
Connecting rooms with bath	3.80

ROSSLYN HOTELS

111 W. Fifth St. (MIchigan 3311)

Mr. E. S. Heckler, Manager

Single room without bath, one person	$1.50
Double room without bath, two persons	2.00
Single room with bath, one person	2.00
Double room with bath, two persons	3.00

WILLIAM PENN HOTEL

2208 W. Eighth St. (EXposition 3181)

Mrs. Dawn Olson, Manager

Single room with bath, one person	$2.00
Double room with bath, two persons	2.50
With twin beds	3.50

TOWN HOUSE HOTEL

639 Commonwealth Ave. (EXposition 1234)

Mrs. C. W. Gaskell, Manager

Single room with bath, one person	$ 6.00
Double room with bath, two persons	7.00
Single suites with baths	10.00

HOTEL STILLWELL

838 S. Grand Ave. (TRinity 1151)

Mr. F. W. Morris, Manager

Single room with bath, one person	$3.50
Double room with bath, two persons	4.00

SAVOY HOTEL

601 W. Sixth St. (MAdison 1411)

Mrs. Leslie Consolloy, Manager

Single room without bath, one person	$2.00
Double room without bath, two persons	2.75
Single room with bath, one person	2.75 up
Double room with bath, two persons	2.75 up

CARLTON HOTEL

529 S. Figueroa St. (MIchigan 6571)

Mr. Tom Miles, Manager

Single room with bath, one person	$2.00
Double room with bath, two persons	3.00
Two double rooms, bath between, per suite	5.00

MONARCH HOTEL

905 W. Fifth St. (MIchigan 7311)

Mr. J. Westerbach, Manager

Single room with bath, one person	$2.00
Double room with bath, two persons	3.00

OTHER MEETINGS

In former years, special conferences were held on the day immediately preceding the annual session (Sunday), for work by the following C.M.A. groups: Clinical Conference on Cancer; Conference on Microscopic Pathology; Conference on Radiology.

This year, it was decided by these study groups that it was not desirable to attempt to hold conferences.

XI

OTHER MEETINGS

CALIFORNIA HEART ASSOCIATION SCIENTIFIC PROGRAM

Hotel Biltmore, Los Angeles

Saturday, May 1, 1943

GUEST SPEAKERS

George Blumer, M.D., David P. Smith, Professor of Medicine, Emeritus, Yale University; and Alvin G. Foord, M.D., Pathologist, Huntington Memorial Hospital, Pasadena.

MORNING SESSION—9:30 A.M.

I. *Acute Gout Caused by Aminophyllin*—Wilbur A. Beckett, M.D., Los Angeles.

II. *The Symptom Complex of Angiitis, Myocardial Insufficiency and Eosinophilic Leukocytosis*—Gurth Carpenter, M.D., Los Angeles.

III. 1. *The Incidence of Acute Rheumatic Fever in Southwestern United States*—Samuel J. McClendon, M.D., San Diego.
2. *Rheumatic Infection in a Plateau Area*—Lieut. Comdr. R. F. McLaughlin, MC, U.S.N.R., Oakland.
(The above papers will be discussed jointly.)

IV. *Circulatory Changes in Obstetrical Labor*—Ellen Brown, M.D., San Francisco; John J. Sampson, M.D., San Francisco; and Edwin Wheeler, M.D., San Francisco.

V. *Traumatic Rupture of Normal Heart Valves*—Francis L. Chamberlain, M.D., San Francisco; and Warren L. Bostick, M.D., San Francisco.

VI. *Symmetrical Gangrene of the Extremities*—Hilliard Katz, M.D., San Francisco; Francis L. Chamberlain, M.D., San Francisco; and Edwin L. Bruck, M.D., San Francisco.

Luncheon Recess—12:00 o'clock noon

AFTERNOON SESSION—1:30 P.M.

VII. *Arterio-venous Communications in the Human Heart*—Myron Prinzmetal, M.D., Los Angeles; and Clara Margolies, M.D., Los Angeles.

VIII. *Studies on the Circulation with Fluorescein*—Morris H. Nathanson, M.D., Los Angeles; and R. Merliss, M.D., Los Angeles.

IX. *Annual Business Meeting—California Heart Association*—Presiding, Lieut. Comdr. Harold Rosenblum, MC, U.S.N.R., San Francisco.

X. *Subdural Hematoma as a Result of Blast Injury*—Lieut. Comdr. Walter D. Abbott, MC, U.S.N.R., Oakland.

XI. *Theoretical Considerations in the Use of Anticoagulants in Coronary Occlusion*—Hugh A. Edmondson, M.D., Los Angeles.

XII. *Hypertension in Only One of Identical Twins*—J. S. Kasanin, M.D., San Francisco; and Captain Meyer Friedman, M.C., San Francisco.

XIII. *Two Clinical-Pathological Cases*—George Blumer, M.D., Pasadena; and Alvin G. Foord, M.D., Pasadena.

XIV. *Extrarenal Azotemia and Heart Disease*—Leslie Bennett, M.D., San Francisco.

CALIFORNIA STATE BOARD OF PUBLIC HEALTH

The California State Board of Public Health will hold a meeting at Hotel Biltmore on Sunday, May 2, 1943.

The Board will be pleased to hear any members of the medical profession who may desire to call attention to public health problems or needs. Place and hour of the meeting will be posted on the Bulletin Board.

WESTERN ASSOCIATION OF INDUSTRIAL PHYSICIANS AND SURGEONS

Thursday, April 29—Saturday, May 1, 1943

The Western Association of Industrial Physicians and Surgeons will hold its third annual convention on April 29, 30, and May 1, just preceding the annual session of the California State Medical Association. The program is comprehensive and devoted solely to the problems of industrial medicine. Among the guest speakers from the East are:

Dr. William Sawyer, Eastman Kodak Co., Rochester, N. Y.

Prof. Philip Drinker, of Harvard University, Boston, Mass.

Dr. Robert A. Kehoe, Kettering Laboratory, Cincinnati, Ohio.

Dr. Lyman D. Heacock, Dental Surgeon, Bethesda, Maryland.

Dr. Franklin Bing, Ph.D. (tentative), Chicago, Ill.

The above list will be augmented by outstanding physicians of the Pacific Coast area, who will present a symposium dealing with Post-War Rehabilitation in Industry; Minor Traumata; Surgery of the Extremities; Differential Diagnosis of Low Back Pain; Repair of Nerves and Tendons, and other interesting subjects.

Not the least important phase of the convention will be the exhibit of industrial hazards, such as occur in welding, spray painting, electroplating, and degreasing.

A field trip to some of the industrial plants is contemplated for Saturday morning, May 1. Hotel Biltmore will be the headquarters.

For further information, address the Secretary, R. T. Johnstone, M.D., Golden State Hospital, 423 Towne Ave., Los Angeles. (Telephone, TRinity 8231.)

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MRS. F. G. LINDEMULDER
President, Woman's Auxiliary to the California Medical Association
1943



MRS. LAWRENCE K. GUNDRUM
Recording Secretary, Woman's Auxiliary to the California Medical Association
1943

WOMAN'S AUXILIARY

Fourteenth Annual Session

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION

Headquarters at Hotel Biltmore, Los Angeles

Mrs. F. G. Lindemulder, *President*

Mrs. William R. Molony, Jr., *Convention Chairman*

Saturday, May 1

Arrival of delegates, members and guests, greeted by the Convention Hostesses.

2:00 p. m.-6:00 p. m.—Registration. Hotel Biltmore.

7:00 p. m.-9:00 p. m.—Registration.

7:00 p. m.—Pre-Convention Board Meeting.

Sunday, May 2

9:00 a. m.-1:00 p. m.—Registration.

9:30 a. m.—Annual Business Session of the Woman's Auxiliary to the California Medical Association. All members and doctors' wives are invited to attend.

1:30 p. m.—Luncheon at the Hotel Biltmore, honoring the President, President-Elect, Past State Presidents and Advisory Board.

Monday, May 3

9:00 a. m.-11:00 a.m.—Registration.

9:30 a. m.—Post-Convention Board Meeting.

10:30 a. m.—Symposium with Round Table Discussion for all County Officers, Chairman, Members welcome.

12:30 p. m.—Informal luncheon and Fashion Show at Bullock's Wilshire.

3:00 p. m. -5:00 p. m.—Tea for all doctors' wives attending Convention at the Hotel Biltmore.

CONVENTION COMMITTEES
Los Angeles, May 2-3, 1943

Convention Chairman.....Mrs. Wm. R. Molony, Jr.
Local Chairman.....Mrs. Ludwig L. Kaftan
Credentials and Registration.....Mrs. Charles Rees
Local Chairman.....Mrs. Geo. P. Landegger
Transportation.....Mrs. Benj. H. Sherman
Information.....Mrs. C. Raphael Dunlevy
Decorations and Flowers.....Mrs. L. C. Burwell
Ushers and Pages.....Mrs. Paul D. Foster
Printing and Supplies.....Mrs. Edwin B. Plimpton
Badges.....Mrs. John Martin Askey
Finance.....Mrs. Arthur J. Annis
Emergency.....Mrs. Robert C. Donham
Hostess.....Mrs. Franklin Farman
Sunday Luncheon.....Mrs. Clifford Wright
Monday Luncheon.....Mrs. Wm. C. Boeck
Monday Afternoon.....Mrs. Newell Jones
Publicity.....Mrs. Ward Rolland
Long Beach Chairman.....Mrs. Burns Chaffee
Pasadena Chairman.....Mrs. L. G. Hunnicut

Part II

PRE-CONVENTION BULLETIN

FOREWORD.—The official reports which follow will be presented at the coming session of the House of Delegates.

Delegates, therefore, are urged to familiarize themselves with their contents.

Members, likewise, are requested to become familiar with the recommendations in these reports, and to discuss them with other members and delegates.

* * *

I

REPORTS OF GENERAL OFFICERS

REPORT OF THE PRESIDENT

To the House of Delegates:

Two years ago you conferred upon me the greatest honor that a practicing physician can receive from his fellow practitioners. After a year of apprenticeship, during which I had the pleasure of visiting many of the County Societies and sitting in on many meetings and conferences, I had the added pleasure of being installed as the President of your great organization.

Many of the dreams that may have been mine as to what I would do during my incumbency have been shattered by the demands of the "all war effort." I had hoped that it would have been my privilege and pleasure to have visited each of you in your County Society; to have discussed with you our mutual problems, to work out plans and methods for improvement in our relations to each other and to the citizens of your communities.

Our armed services have taken hundreds of our members and have asked for 1200 more during 1943. These have gone to augment the medical departments of the Army, the Air Corps, the Navy and the Public Health and while at home or across the seas will represent part of our effort to win this war.

The loss in membership, carrying with it a considerable decrease in income, has been a problem that has given your officers much concern. Thanks to the efficient organization of the Secretary's office and the unselfish devotion of the Executive Committee and the Council, what might have been a deficiency has been carried through without sacrificing any of the activities which have made this organization worthwhile.

The California Physicians' Service, along with other groups seeking to maintain the competitive way of American medicine, has had its troubles. These have been in the main brought about by some impatience with the progress of the plan and by the lack of coöperation by one of the Hospital Associations.

Your officers have spent much time and effort to iron out these differences. Several meetings of the Council and Executive Committees were held to which were invited representation of each group. I am convinced that before 1943 comes to a close the medical profession, the hospital associations and the California Physicians' Service will walk hand in hand and really work out a plan which will go a long way to answer the demands of planned pre-paid medical care.

It was my pleasure to meet with the Vallejo medical group at a time when the medical care of an enormous number of new families had descended upon them. To the credit of these men let it be said that they coöperated fully and probably by doing so prevented the moving in of the Public Health Service.

Major Seeley, as a representative of the National Procurement and Assignment, visited California and delivered addresses in San Francisco, Oakland, Sacramento, Fresno, Los Angeles and San Diego. These meetings were largely attended and served to give a strong impetus towards a more rapid enlistment of medical men into the various branches of the armed services.

I attended the Fresno meeting and escorted Major Seeley to Los Angeles, where conferences were held by the Procurement and Assignment group. Out of Major Seeley's visit and from the splendid Procurement and Assignment State organization headed by Harold Fletcher for Northern California and E. M. Pallette for Southern California, has come a smoothly working organization that has dispelled confusion and in its place given to the medical profession of California a sane and efficient plan which has proven a haven to the disturbed profession.

A statewide survey of medical needs has been made and is constantly being revised which has promptly and effectively prevented the moving in of governmental agencies which would like nothing better than to get an opening wedge into medical care and begin medical regimentation.

We had hopes that the American Medical Association in spite of many rumors of a disquieting and discouraging nature would hold its meeting in San Francisco during this year. It was when positive information came from the director of transportation, in consultation with the Army and Navy, that the Board of Trustees reluctantly voted to cancel the meeting for 1943.

Being close to the Pacific theatre of war, we can appreciate the difficulty of providing adequate transportation to the large numbers who would undoubtedly want to attend. This in addition to a nation-wide shortage of available medical men served to convince us that the decision of the Board of Trustees was a wise one. We have the assurance that following the winning of the war the first meeting of the American Medical Association will be held in San Francisco.

Looking backward over the year which we faced with misgivings as to how the medical profession would be able to carry on, it can be said with a great deal of satisfaction that we have met all of the problems and have worked out a solution to each.

Looking forward to the immediate future, save for a severe epidemic or a major catastrophe, I think that it can be said with assurance that those of our organization who have not entered the services are ready and willing to meet every medical need that the civilian population may require.

Respectfully submitted,
WILLIAM R. MOLONY, SR., *President.*

REPORT OF THE PRESIDENT-ELECT

To the President and House of Delegates:

The activities of the President-elect for the past year have been confined largely to the work as Chairman of the Procurement and Assignment Committee of the Ninth Corps Area and to the problems of Hospital Service plans in their relation to California Physicians'

Service. This responsibility has of necessity limited the usual program of this officer to the routine work of the Executive Committee and Council and has made the customary visits to County Societies impossible.

Respectfully submitted,

KARL L. SCHAUPP, *President.*

REPORT OF THE PAST PRESIDENT

To the President and House of Delegates:

During the past year I have attended all Council and Executive Committee meetings.

I have served the California Medical Association in various capacities for the past eighteen years. This service has been a pleasure. I have enjoyed, throughout the entire period, the friendship of all of you. This work, I believe, has made me become a better physician and I wish to thank you for the honor and privilege of permitting me to serve you.

Respectfully submitted,

HENRY S. ROGERS, *Past President.*

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

To the President and the House of Delegates:

There is no doubt that attendance on the House of Delegates for the forthcoming session will be a hardship on many, or perhaps most of the delegates. This is because the brief nature of the general meeting of the California Medical Association which, due to the exigencies of the war effort, has robbed the annual meeting of many of its attractions. Nevertheless, it must be apparent to all delegates that the business of the Association must go on and that it is more important than ever that Organized Medicine maintain a solid front, and advance a constructive program.

To that end, the delegates and alternates are begged to appear promptly at 12:00 noon on Sunday, May 2, and at 1:00 p.m. on Monday, May 3.

Respectfully submitted,

LOWELL S. GOIN, *Speaker.*

REPORT OF VICE-SPEAKER

To the President and the House of Delegates:

The report of your Vice-Speaker can contain nothing of great importance. My duties have consisted in observing and attending, by invitation, meetings of the Council and standing ready to lend such support as needed to the Speaker.

There have been many problems arising which have been met ably by your officers. I stand ready to do such duties as you may call upon me to perform.

Respectfully submitted,

E. VINCENT ASKEY, M. D., *Vice-Speaker.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

To the President and the House of Delegates:

The Council submits in the "Pre-Convention Bulletin" a tentative report. At Los Angeles additional reports may be made. The large amount of business coming before the Council must be evident to all who read the minutes of its meetings. Many of the matters that have been under consideration in the Council will be presented also to the House of Delegates.

Respectfully submitted,

PHILIP K. GILMAN, *Chairman of the Council.*

REPORT OF THE COUNCIL

To the President of the House of Delegates:

The Council herewith submits a preliminary report for the 1942-1943 Association year. A further report, or additions and changes in this report, may be made at the time of the 1943 Annual Session.

1. Meetings.

Since the conclusion of the 1942 Annual Session the Council has held three meetings, including an organization meeting at Del Monte on May 7, 1942, a meeting in Los Angeles on September 13, 1942, and a meeting in Los Angeles on February 28, 1943. In addition, the Council has reviewed and approved the actions of the Executive Committee in meetings held on May 7, July 11, September 8, and December 6-13, 1942, and February 7, 1943.

These meetings comply with constitutional provisions as to the frequency of meeting. Minutes in abstract form have been printed in CALIFORNIA AND WESTERN MEDICINE.

2. Membership.

The Association's membership at the close of 1942 amounted to 7,116 active members, a gain of 227 members over the 1941 year-end total. The California Medical Association ranks as the fourth largest state unit of the American Medical Association. Of our membership, 1,482 members were in active military service with the armed forces of the United States as of last December 31. This number is bound to increase as 1943 progresses. These members are carried as active members, with their dues waived, during their period of active duty.

3. Finances.

The Association's finances have been maintained in excellent shape since the 1942 meeting of the House of Delegates. Although more than $57,000 was expended during 1942 on the Basic Science Act, it was possible to use current funds for practically all of this amount and to draw on accumulated reserves for only a small sum. Early in 1943 it was voted to repay to the Trustees of the California Medical Association the sum of $15,000. This payment will reduce the Association's indebtedness to the Trustees of the C.M.A. to $31,303.07. The Trustees have voted to invest this $15,000 repayment in Government bonds.

4. California Physicians' Service.

Much thought has been given in the past year by the Council to the affairs of California Physicians' Service. This child of the C.M.A. has been called upon to branch out somewhat from its original conception as a means of meeting wartime demands and of relieving overworked practicing physicians from undue wartime loads. C.P.S. has accomplished a large measure of success in this direction in the setting up of medical centers and medical services in federal housing areas in San Diego, San Pedro, Vallejo and Marin City. In each instance, C.P.S. has been able to render a high type of medical care on the basis of a prepaid plan in which the Government has taken an active part.

C.P.S. has also continued in the last year its coverage of farm families under the Farm Security Administration program. Although this type of service has

not been as rapid in growth as has the housing area service, the financial returns to C.P.S. professional members have been maintained at a satisfactory level throughout the entire period of the service.

During the past year C.P.S. has been converting its full-coverage contracts to either a surgical or a two-visit-deductible coverage. These conversions, which are expected to be completed my mid-1943, have already tended to increase the unit value for professional members, and it is anticipated that a further improvement will result from the completion of the conversion program.

C.P.S. has had differences of opinion in the past year with Hospital Service of California, through which C.P.S. has been writing its hospitalization insurance in central California areas. These differences have led to a decision by Hospital Service of California to offer for sale a surgical indemnification policy; C.P.S., likewise, has decided to write its own hospitalization coverage in the areas formerly served by Hospital Service. The Council and the Executive Committee have studied these differences and have decided to have a complete survey of the California situation made by an outside expert. This survey will be completed, or will at least be under way, by the time of the 1943 Annual Session, and it is hoped that out of it may come some suggestions which will permit a more coöperative working arrangement in California in the offering of hospitalization and medical care for the civilian population.

The Council stands firmly on the belief that hospitalization organizations should stay strictly within the field of hospitalization, as defined by the American Medical Association, and should not become insurance companies whose main interest is the making of money.

5. Basic Science Act.

The Council, acting on instructions from the House of Delegates, carried on the campaign last year on the Basic Science Act, known on the November, 1942, ballot as Proposition Number 3. Much time was given over by the C.M.A. office and by officers and members of the Association, as well as by outside employed interests, to the promotion of this measure. The California voters, however, voted rather impressively against this bill, and California is still left without the protection that such legislation could offer. Various reasons have been advanced for the failure of Proposition Number 3, not the least of which is the fact that so many of the active C.M.A. members were in military service and could not participate in the campaign.

The Council expresses here the opinion that the Basic Science Act was and is basically sound for the protection of the public health in California and should be remembered as a piece of constructive legislation which should be placed on the California statute books, in its present or amended form, some time in the future.

6. Industrial Accident Commission Fee Schedule.

The increased fee schedule voted at the 1942 House of Delegates was drawn up under the Council's supervision in the fall of 1942, and presented to the Industrial Accident Commission late last year. The Commission held a public hearing on the proposed schedule on February 15, 1943, and the results of this hearing are not known at this writing. The schedule is under submission to the Industrial Accident Commission. However, the Council has already given a vote of thanks to the members of the committees charged with preparing and presenting the proposed fee schedule.

It is the hope of the Council that the schedule presented, with little or no amendment, may be adopted by the Industrial Accident Commission and may serve as a pattern for similar schedules in other states. In its proposed form, the schedule lists 543 separate operations and procedures, compared with only 78 shown on the skeleton fee schedule used by the Industrial Accident Commission for the past 23 years.

In presenting the proposed fee schedule to the Industrial Accident Commission, legal counsel pointed out that the present fee schedule has been in effect since 1920, that its fees were inadequately and incompletely set in the first instance, and that the rise in the cost of living and the cost of everything which enables the doctor to exist has been so great in the past 23 years that the old fees were hopelessly understated. It was also pointed out that the doctor's fee is the only item in the "medical cost" of compensation insurance companies which comes within the scope of the Commission's authority; nursing fees, hospitals, drugs, dressings and appliances have all risen in cost in the 1920-1943 period and have been paid for without complaint by the insurance companies. It is now hoped that the Industrial Accident Commission will recognize the justice of a similar increase in the fees of professional men upon whom depends the entire industrial compensation structure in California.

7. Procurement and Assignment Service.

The Council wishes to pay tribute to the excellent work performed by Doctor Harold A. Fletcher and Doctor Edward M. Pallette and their committee members in Procurement and Assignment Service. Due to their untiring efforts, California was able to achieve a signal degree of success in 1942 in the national program, without causing a disruption of medical services essential to the civilian or industrial populations.

8. Legislation.

The Council has reviewed the legislation now pending before the Legislature in Sacramento and has instructed the Committee on Public Policy and Legislation with respect to the various measures. The Association has not introduced one bill in this session but has voted to offer certain amendments to various bills from other interests. The Committee on Public Policy and Legislation is considered amply able to handle the Association's legislative program.

9. Visits to County Societies.

This function of the Council has been carried on in the past year by the individual Council members and, where possible, by the officers of the Association. Transportation difficulties make it impossible for the officers to maintain a full schedule of county society visits, but such visits will be made when and where they are desired and can be planned.

10. Committee on Public Health Education.

The 1942 House of Delegates voted to wipe out any obligation against members who had not paid the 1939 Special Assessment by which the Committee on Public Health Education was founded. The funds of the committee were exhausted in February, 1943, and the committee has now gone out of existence, in accordance with the original term of its appointment.

11. Annual Session.

The 1943 Annual Session will be held at Hotel Biltmore, Los Angeles, on May 2 and 3, 1943. Scientific programs have been arranged to give a maximum of coverage in a minimum amount of time; these programs promise to bring forth some exceptionally good material and to furnish for CALIFORNIA AND WESTERN MEDICINE a supply of scientific articles of particular merit.

12. Woman's Auxiliary.

The Council again expresses its thanks to the Woman's

Auxiliary for its efforts during the past year. It is hoped that the Woman's Auxiliary may continue to be as constructive a force in the future as it has proved itself to be in the past.

13. **General.**

The Association's office is being managed in a capable manner and the business of the Association expedited and properly transacted.

Respectfully submitted,

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION.
By the Chairman:
PHILIP K. GILMAN.

REPORT OF THE PRESIDENT OF THE TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION

To the President and the House of Delegates:

The financial report of the Trustees of the California Medical Association, as submitted by the Certified Public Accountants, appears in this "Pre-Convention Bulletin," in the report of the Association Treasurer.

As has been stated in previous years, the nonprofit corporation, "Trustees of the California Medical Association," has as its members during any year, the general officers and the councilors of the Association of that year. The corporation, in accordance with the corporate laws of the State, acts as the custodian of endowment and special funds that may be transferred to it for custodial supervision and care.

Respectfully submitted,

P. K. GILMAN, *President.*

REPORT OF THE SECRETARY-TREASURER

To the President and the House of Delegates:

Following past custom, your Secretary-Treasurer submits his report under two subheadings: (1) Report of the Association Secretary, and (2) Report of the Treasurer.

I. Report of the Secretary

Shortly after the onset of War II, with the Nation's need for evergrowing Armed Forces, in which an adequate medical personnel is a most essential part, it became evident that members of the medical profession would be obliged to solve many new problems. The entrance of large numbers of physicians into military service meant increasing loads for colleagues who continued in civilian practice. As a consequence, component county medical societies were not in position to hold scientific and other meetings with the same frequency as heretofore; and because of the disarrangements in civil life and the need for military purposes, of public properties such as fair grounds, the opportunities for postgraduate clinics, public health exhibits at county fairs, and visits to component county units by State Association Officers automatically came to almost an abrupt end. During the Duration, these activities may be able to manifest themselves only in gesture form.

The Association Secretary, as an ex-officio member of the House of Delegates, the Council, the Executive and several standing Committees, has been called on to prepare the agenda of the meetings, and perform special duties for which these various bodies may have given instructions.

Again, in his ex-officio capacity, as chairman of the Committee on Scientific Work, he has given attention to the details of preparation of the programs for the Annual Session and the arrangements for its scientific meetings and activities.

These and other phases of the Association Secretary's work are covered in reports by these various bodies and need no recapitulation here. For the continued generous coöperation received from State and Component County Society Officers and Members whom he has been obliged to consult in his work, the Association Secretary again expresses his thanks.

II. Report of the Treasurer

The report of the Certified Public Accountants, Messrs Hood and Strong, which follows, gives a survey of income and expenditures, regarding:

(1) California Medical Association activities, both as based on income from dues and current maintenance and administrative expenses; and

(2) On the reserve funds held by the "Trustees of the California Medical Association," (a nonprofit corporation composed of the year-by-year general officers, who function as a holding company under the corporate laws of the State).

Upon instruction from the Executive Committee, the report of the Certified Public Accountants is printed in full, to permit the component county societies and all members who may be interested, to better orient themselves concerning the resources of the California Medical Association, its income and expenditures. Should additional information be desired, the same will be furnished by the headquarter's office. If the House of Delegates wishes the publication of the complete reports of the Certified Public Accountants to be continued, it should so indicate.

Respectfully submitted,

GEORGE H. KRESS, *Secretary-Treasurer.*

* * *

Report of the Certified Public Accountants, Hood and Strong, San Francisco, follows:

Report of Examination*
I. California Medical Association
and of
II. Trustees of the California Medical Association
(A Corporation)
San Francisco, California
December 31, 1942

HOOD AND STRONG
CERTIFIED PUBLIC ACCOUNTANTS
SAN FRANCISCO

January 20, 1943

CALIFORNIA MEDICAL ASSOCIATION,
San Francisco, California.

Gentlemen:

Pursuant to your instructions, we have made an examination of the accounts and records of CALIFORNIA MEDICAL ASSOCIATION for the year ended December 31, 1942, and present hereinafter the following statements:—

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION):—
- COMBINED BALANCE SHEET—DECEMBER 31, 1942

CALIFORNIA MEDICAL ASSOCIATION:—
- BALANCE SHEET—DECEMBER 31, 1942
- STATEMENT OF INCOME AND EXPENDITURE—COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1942 AND DECEMBER 31, 1941
- EXPENDITURE—COMPARATIVE FOR YEARS ENDED DECEMBER 31, 1942 AND DECEMBER 31, 1941

SPECIAL ASSESSMENT FUND:—
- BASIC SCIENCE LAW FUND
- BALANCE SHEET—DECEMBER 31, 1942
- STATEMENT OF RECEIPTS AND DISBURSEMENTS—JANUARY 1, 1942 TO DECEMBER 31, 1942

We have also made an examination of the accounts of the Trustees of the California Medical Association, a nonprofit corporation, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements herein submitted, and indicate, generally, the scope of our examination:—

Combined Balance Sheet—December 31, 1942

California Medical Association and Trustees of the California Medical Association (A Corporation)

This statement exhibits, in condensed form, the combined assets and liabilities of both organizations. The assets and liabilities of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the assets and liabilities of the Trustees of the California Medical Association (a corporation).

Balance Sheet—December 31, 1942

California Medical Association

CASH—$32,765.92:

We verified the amount on deposit in banks from the basis of confirmations received directly by us from the depositaries. The petty cash fund was counted.

ACCOUNTS RECEIVABLE—$1,629.36:

These consist of Journal advertisers, in the amount of $2,171.36, less the sum of $42.00 paid in advance by Las Encinas Sanitorium; the sum of $500.00 has been deducted as a Reserve to provide for loss in collection.

The age of the accounts amounting to $2,171.36 is as follows:—

Five accounts listed. (Names here omitted)	$ 73.50
Balance which may be considered as current	2,097.86
	$2,171.36

We examined accounts totaling this sum, but we did not verify the amounts by direct correspondence with the individual debtors.

CASH LOANS AND ADVANCES—$39,300.00:

Loans to the California Physicians' Service, of $39,300.00, represent notes as follows:—

	Date	Due	Face Amount	Payments	Balance
1	Without Interest Feb. 13, 1939	Feb. 13, 1940	$ 5,000	$2,700	$ 2,300
2	Without Interest Sept. 21, 1939	Sept. 21, 1940	10,000		10,000
3	Dec. 22, 1939	Dec. 22, 1942	6,000		6,000
4	Jan. 19, 1940	Jan. 19, 1943	6,000		6,000
5	Apr. 18, 1940	Apr. 18, 1943	10,000		10,000
6	Sept. 25, 1940	Sept. 25, 1943	5,000		5,000
			$42,000	$2,700	$39,300

These notes were verified by inspection. Notes No. 1, No. 2 and No. 3 are past due. No payments were received during the year.

TRUST FUND—$1,155.49:

This item represents the amount of the Morris Herzstein Bequest Savings Account, which amount was verified to us by the Wells Fargo Bank & Union Trust Co. The changes during the year were as follows:—

Balance, January 1, 1942	$1,589.62
Income	630.25
	$2,219.87
Less payment of Loan to the California Medical Association	1,064.38
Balance, December 31, 1942	$1,155.49

The income was verified from a photostatic copy of a statement of receipts and disbursements as prepared by the Trustee as to the Trust Income, and from savings bank pass books as to interest.

BENEVOLENCE FUND—$2,141.50:

This was formerly the Fund for Needy Members, the name being changed by authority of the Council at its meeting on January 17, 1942. This amount is made up as follows:—

Balance, January 1, 1942		$6,870.64
Additions, Donations from County Woman's Auxiliaries		735.00
		$7,605.64
Less transfer to Trustees of California Medical Association to comply with minutes of Council at their meeting of January 17, 1942	$4,324.64	
Disbursements	1,139.50	5,464.14
Balance, December 31, 1942		$2,141.50

The balance was confirmed to us directly by the Crocker First National Bank.

DEFERRED CHARGES—$891.37:

Details of this asset appear on the Balance Sheet and call for no further comment. In our opinion they are correctly stated.

Liabilities

ACCOUNTS PAYABLE—$48,460.72:

The composition of this item is as follows:—

Due to Trustees of the California Medical Association	$46,498.07
Due to the Indemnity Trust Fund	137.50
Journal Production accrued expense	1,471.08
Miscellaneous	354.07
	$48,460.72

The amount of $46,498.07 due to the Trustees of the California Medical Association (a Corporation) is in agreement with the accounts of that Association. All liabilities of which we have knowledge have been accounted.

DEFERRED INCOME—$60.00:

This amount represents dues received in advance.

TRUST FUNDS—$3,296.99:

The assets representing this item have been commented upon hereinabove.

RESERVES—$39,300.00:

This item represents a provision for possible loss in the collection of the $39,300.00 advanced to the California Physicians' Service.

DEFICIT—$13,233.07:

Changes in the Deficit during the year ended December 31, 1942, are shown in the following:—

Balance, January 1, 1942		$ 447.21
Dues for 1941 charged off		4,803.75
Excess of Expenditures over Income		9,529.89
		$14,780.85
Transfer from Reserve for Contingencies		1,000.00
		$13,780.85
Credits applicable to prior years		547.28
Balance, December 31, 1942		$13,233.07

* * *

Statement of Income and Expenditure

In this statement are shown the income and expenditure for the years 1942 and 1941, together with the increase or decrease in each item.

As to Membership Dues, this income was verified by correspondence with several of the County Societies selected by us at random, asking them to confirm directly to us, the amount remitted by them for dues during the

year. From the basis of replies received, we are satisfied that dues are being properly received and accounted.

The income from exhibitors at the Annual Meeting was test-checked to letters and agreements on file.

Income from advertisements in the Journal, CALIFORNIA AND WESTERN MEDICINE, was test-checked by us to advertisements appearing in the December, 1942, issue of that periodical.

Expenditures were verified from cancelled checks and by inspection of vouchers, where necessary. Minutes of the meetings of the Council, Trustees, etc., were reviewed by us for authorization of the larger expenditures.

Authorization was given at the annual meeting to waive all dues of new members who were on military duty at the time of joining the Association. Authorization was also given to cancel charges against members for dues assessed subsequent to their joining the armed forces.

* * *

SPECIAL ASSESSMENT FUND—BALANCE SHEET DECEMBER 31, 1942

Cash of $899.39 on deposit in the American Trust Company was verified by confirmation received by us directly from the depositary.

Pursuant to a resolution of the House of Delegates, all monies collected under an assessment levied in 1939 are to be carried in a special fund and used only for educational purposes as specified in the resolution. No monies were collected for this fund during 1942.

It is our understanding that any amount remaining in this special fund after the discharge of the Committee on Public Health Education by the House of Delegates, is to be returned pro rata, to the members of the Association who paid the special assessment.

SPECIAL ASSESSMENT FUND—STATEMENT OF RECEIPTS AND DISBURSEMENTS

As stated above, no monies were received by this fund during the year 1942, and we have satisfied ourselves, to the extent practicable, that the disbursements have been proper, and that the balance on hand is correctly stated.

Very truly yours,
(Signed) HOOD AND STRONG.

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

BALANCE SHEET — DECEMBER 31, 1942

ASSETS			
Cash		$32,765.92	
On Deposit	$32,683.12		
Commercial Accounts	$ 6,443.34		
Savings Accounts	26,239.78		
Petty Cash Fund	82.80		
Accounts Receivable		1,629.36	
Journal Advertisers: Total	2,129.36		
Less Reserve for Doubtful Accounts	500.00		
Cash Loans and Advances		39,300.00	
California Physicians' Service	39,300.00		
Trust Funds		3,296.99	
Morris Herzstein Bequest — Savings Account	1,155.49		
Benevolence Fund	2,141.50		
Furniture and Fixtures— Nominal Value		1.00	
Deferred Charges		891.37	
Rent paid in advance	274.00		
Equipment for Annual Meeting	400.27		
Mailing Expense—Journal, January, 1943	95.00		
Miscellaneous Expense	122.10		$77,884.64
LIABILITIES			
Accounts Payable		48,460.72	
Due to Trustees of the California Medical Association	46,498.07		
Indemnity Trust Fund	137.50		
Journal Production—Accrued Expense	1,471.08		
Miscellaneous	354.07		
Deferred Income		60.00	
Dues received in advance	60.00		

CALIFORNIA MEDICAL ASSOCIATION AND TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)
San Francisco, California

COMBINED BALANCE SHEET — DECEMBER 31, 1942

	CALIFORNIA MEDICAL ASSOCIATION	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	ELIMINATIONS	COMBINED DECEMBER 31, 1942	COMBINED DECEMBER 31, 1941	INCREASE *Decrease*
ASSETS						
Cash	$32,765.92	$ 5,999.33		$ 38,765.25	$ 50,146.35	*$11,381.10*
Marketable Securities		42,129.42		42,129.42	42,129.42	
Due from California Medical Association		46,498.07	$46,498.07			
Accounts Receivable	1,629.36			1,629.36	1,641.01	*11.65*
Endowment Fund		252.44		252.44	245.64	6.80
Benevolence Fund	2,141.50	4,369.30		6,510.80	6,870.64	*359.84*
Trust Fund	1,155.49	49,708.00		50,863.49	50,202.15	661.34
Furniture, Equipment, etc.	1.00			1.00	1.00	
Deferred Charges	891.37			891.37	1,189.54	*298.17*
Other Assets	39,300.00			39,300.00	45,243.13	*5,943.13*
	$77,884.64	$148,956.56	$46,498.07	$180,343.13	$197,668.88	*$17,325.75*
LIABILITIES, RESERVES AND SURPLUS						
Due to the Trustees of the California Medical Association	$46,498.07		$46.498.07			
Other Accounts Payable	1,825.15			$ 1,825.15	$ 2,729.33	*$ 904.18*
Due to the Indemnity Defense Fund	137.50	135.00		272.50		272.50
Members' Contributions to Endowment Fund		252.44		252.44	245.64	6.80
Benevolence Fund	2,141.50	4,369.30		6,510.80	6,870.64	*359.84*
Deferred Income	60.00			60.00	4,743.00	*4,683.00*
Trust Fund	1,155.49	49,708.00		50,863.49	50,202.15	661.34
Reserves	39,300.00			39,300.00	40,300.00	*1,000.00*
Surplus	*13,233.07*	94,491.82		81,258.75	92,578.12	*11,319.37*
	$77,884.64	$148,956.56	$46,498.07	$180,343.13	$197,668.88	*$17,325.75*

Trust Funds		3,296.99	
Unexpired balance of Income received under Herzstein Bequest	1,155.49		
Benevolence Fund	2,141.50		
Reserves		39,300.00	
For Possible Loss on Loans	39,300.00		91,117.71
Deficit			13,233.07
Representing the amount by which the liabilities and Reserves for possible losses exceed the total assets of the Association at December 31, 1942			$77,884.64

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

STATEMENT OF INCOME AND EXPENDITURE
COMPARATIVE FOR YEARS ENDED
DECEMBER 31, 1942 AND DECEMBER 31, 1941

	YEAR ENDED DECEMPER 31, 1942	YEAR ENDED DECEMBER 31, 1941	INCREASE *Decrease*
INCOME			
DUES AND GENERAL:			
Membership Dues—Less portion allocated to Journal Subscriptions	$71,447.00	$82,105.00	*$10,658.00*
Exhibitors at Annual Meeting	7,850.00	7,865.00	*15.00*
California Medical Society—Services	600.00	600.00	
Reprint Sales, etc.	157.47	395.88	*238.41*
Interest Earned	479.80	186.78	293.02
Miscellaneous		130.15	*130.15*
	$80,534.27	$91,282.81	*$10,748.54*
OFFICIAL JOURNAL "CALIFORNIA AND WESTERN MEDICINE":			
Advertising	$25,651.21	$25,381.93	269.28
Members' subscriptions (allocated from dues)	21,378.00	19,312.50	2,065.50
Cash subscriptions	690.05	686.90	3.15
	$47,719.26	$45,381.33	$ 2,337.93
TOTAL INCOME	$128,253.53	$136,664.14	*$ 8,410.61*
EXPENDITURE			
Administrative	$44,175.53	$49,864.10	*$5,688.57*
Scientific, Education and Public Relations	66,692.33	9,799.05	56.893.28
Official Journal—"CALIFORNIA AND WESTERN MEDICINE"	26,915.06	31,603.55	*4,688.49*
TOTAL EXPENDITURE	$137,782.92	$91,266.70	$46,516.22
EXCESS OF EXPENDITURES OVER RECEIPTS	*$ 9,529.39*	$45,397.44	*$54,926.83*

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

EXPENDITURE
COMPARATIVE FOR YEARS ENDED
DECEMBER 31, 1942 AND DECEMBER 31, 1941

	YEAR ENDED DECEMBER 31, 1942	YEAR ENDED DECEMBER 31, 1941	INCREASE *Decrease*
ADMINISTRATION:			
Salary — Association Secretary and Treasurer	$ 3,600.00	$ 3,600.00	
Salary—Executive Secretary	6,600.00	6,000.00	$ 600.00
Salaries—Clerical	7,162.98	6,758.63	404.35
Travel Expense:			
Secretary	208.58	482.27	*273.69*
Officers	304.19	319.39	*15.20*
Council	3,423.32	2,781.08	642.24
Executive Committee	82.95	129.60	*46.65*
A. M. A. Delegates	1,747.30	1,183.60	563.70
Taxes Pay Roll	520.08	484.98	35.10
Annual Meeting Expense	6,466.54	6,545.07	*78.53*
Special Meeting Expense	982.12	955.13	26.99
Legal Expense:			
Retainer Fee	4,000.00	4,000.00	
Other Legal Expense	954.53	1,415.69	*461.16*
Rent	3,288.00	3,288.00	
Office Supplies and Expense	1,272.75	1,683.50	*410.75*
Postage	455.75	635.88	*180.13*
Telephone and Telegraph	779.51	599.65	179.86
Council and Executive Committee Expense	436.82	167.83	268.99
Equipment Expense	203.43	530.10	*326.75*
Interest on Loans		150.00	*150.00*
Miscellaneous	1,686.68	1,591.62	95.06
Donation — Benevolence Fund		6,562.00	*6,562.00*
	$44,175.53	$49,864.10	*$5,688.57*
SCIENTIFIC, EDUCATIONAL AND PUBLIC RELATIONS:			
Contributions to Medical Libraries	$ 2,850.00	$ 3,281.00	*$431.00*
Legislation and Public Policy Expense	3,181.04	3,444.57	*263.53*
Other Committee Activities	2,909.25	1,865.59	1,043.66
Department of Public Relations	347.33	389.74	*42.41*
Appropriations to Promote Basic Science Law	57,404.71	818.15	56,586.56
	$66,692.33	$9,799.05	$56,893.28
OFFICIAL JOURNAL— "CALIFORNIA AND WESTERN MEDICINE":			
Printing	$15,804.18	$21,158.77	*$5,354.59*
Salary Editor	4,000.01	4,000.00	.01
Advertising Commissions	3,666.63	3,761.23	*94.60*
Wrapping and Mailing	1,491.50	1,097.11	394.39
Illustrations	431.37	225.41	205.96
Supplies, Expense and Office Postage	1,223.80	762.43	461.37
Discounts and Collection Expense	247.57	221.98	25.59
Provision for Doubtful Accounts	50.00	376.62	*326.62*
	$26,915.06	$31,603.55	*$4,688.49*
TOTAL EXPENDITURE	$137,782.92	$91,266.70	$46,516.22

Italicized figures = decrease for year 1942.

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California

BASIC SCIENCE LAW FUND

RECEIPTS			$56,330.33
Appropriations by California Medical Association		$53,550.00	
Approved 1/17/42 February	$15,000.00		
Approved 1/17/42 March	7,500.00		
Approved 5/3/42 April	3,000.00		
Authorized 5/3/42 May	10,000.00		
Authorized 7/11/42 July	5,000.00		
Authorized 7/11/42 August	10,000.00		
November	3,050.00		
Other Receipts		2,780.33	
Southern California Dental Association	750.00		
Northern California Dental Association	750.00		
Los Angeles County	1,250.00		
Miscellaneous	30.33		
			$56,330.33

EXPENDITURES		56,320.32
California Associates—Securing Signatures	$30,958.02	
Organizing Outside Counties	3,500.00	
E. C. Shurte	1,115.98	
Mildred Kenny	1,006.45	
Ethel O'Brien	1,317.48	
Walters Mailing Service	7,786.43	
Edna Toole	943.07	
R. H. Alber Co.	6,224.40	
Miscellaneous	3,468.49	
UNEXPENDED BALANCE, DECEMBER 31, 1942		$10.01

Note: In addition to above expenditures the California Medical Association paid bills in the amount of $3,868.63 making the total expenditures for the year $60,188.95.

* * *

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California
SPECIAL ASSESSMENT FUND
BALANCE SHEET DECEMBER 31, 1942

ASSETS

Cash on Deposit—American Trust Company.....$899.39

LIABILITIES

Unexpended Balance of Fund.....$899.39

CALIFORNIA MEDICAL ASSOCIATION
San Francisco, California
SPECIAL ASSESSMENT FUND
STATEMENT OF RECEIPTS AND DISBURSEMENTS
JANUARY 1, 1942 TO DECEMBER 31, 1942

BALANCE OF FUND, JANUARY, 1942			$7,197.22
RECEIPTS			None
			$7,197.22
DISBURSEMENTS			6,297.83
Public Health Education		$6,145.00	
Public Policy and Legislation	$6,000.00		
Reprints and Subscriptions	105.50		
Magazines	39.50		
State and County Fairs.		152.83	
Postage and Express.	103.33		
Storage and Express.	49.50		
BALANCE, DECEMBER 31, 1942			$899.39

Trustees of the California Medical Association
(A Corporation)
Report of Examination
December 31, 1942

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION,
San Francisco, California.
Gentlemen:—

Pursuant to your instructions, we have made an examination of your accounts for the year 1942, and upon the conclusion thereof, have prepared and present hereinafter the following statements:—

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION) AND CALIFORNIA MEDICAL ASSOCIATION:
COMBINED BALANCE SHEET—DECEMBER 31, 1942
TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION):
BALANCE SHEET—DECEMBER 31, 1942
STATEMENT OF INCOME AND EXPENSE—COMPARATIVE FOR THE YEARS ENDED DECEMBER 31, 1942 AND DECEMBER 31, 1941

We have also made an examination of the accounts of the California Medical Association, and have rendered a separate report thereon.

The following comments are submitted in amplification of the various items appearing in the statements herein submitted, and indicate, generally, the scope of our examination:—

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION
(A CORPORATION)
AND CALIFORNIA MEDICAL ASSOCIATION
COMBINED BALANCE SHEET—DECEMBER 31, 1942

This statement exhibits, in condensed form, the combined Assets and Liabilities of both organizations. The assets and liabilities of the Trustees of the California Medical Association will be discussed in detail hereinafter, and a separate report is being presented as to the Assets and Liabilities of the California Medical Association.

* * *

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION
(A CORPORATION)
BALANCE SHEET—DECEMBER 31, 1942
ASSETS

CASH—$5,999.33:

This asset was verified from the basis of certificate received by us directly from the depositary.

INVESTMENTS—$42,000.00:

This consists of Government Securities of a par value of $42,000.00, plus accrued interest of $129.42 to December 31, 1942. Details of these securities are as follows:—

$25,000.00 p.v., U. S. Treasury Bonds 4% —1944/54
2,000.00 p.v., U. S. Treasury Bonds 3¼%—1943/45
5,000.00 p.v., U. S. Treasury Bonds 3⅛%—1949/52
10,000.00 p.v., U. S. Treasury Bonds 3¼%—1944/46

These bonds were verified by us, by inspection at your safe deposit vault.

DUE FROM CALIFORNIA MEDICAL ASSOCIATION—$46,498.07:

This amount is in agreement with the records of that Association, and was verified in our audit of its accounts.

ENDOWMENT FUND—$252.44:

The only change in this account during the year was the addition of savings bank interest of $6.80. This balance was confirmed directly to us by the Bank of America, N. T. & S. A., Humboldt Branch. This fund is offset by a like amount under "Liabilities and Surplus."

BENEVOLENCE FUND—$4,369.30:

This amount represents monies held in trust for the California Medical Association. The account was started in 1942 in conformity with the minutes of the California Medical Association. This fund is offset by a like amount under "Liabilities and Surplus."

TRUST FUND—$49,708.00:

The analysis of this fund is as follows:—

Savings Accounts		$12,286.01
Wells Fargo Bank & Union Trust Co.	$6,145.97	
American Trust Company	6,140.04	
U. S. Government Securities		37,000.00
Accrued Interest to December 31, 1942		149.49
Due from Trustees of the California Medical Association		135.00
Due from California Medical Association		137.50
		$49,708.00

The amounts on deposit were verified by us by direct confirmation from the depositaries.

The United States Government Securities consist of the following:—

$ 2,000.00 p.v., U. S. Treasury Bonds 3¼%—1944/46
5,000.00 p.v., U. S. Treasury Bonds 2¾%—1945/47
10,000.00 p.v., U. S. Treasury Bonds 2½%—1949/53
10,000.00 p.v., U. S. Treasury Bonds 2¾%—Mar. 15, 1948
5,000.00 p.v., U. S. Treasury Bonds 2½%—Dec. 15, 1945
5,000.00 p.v., U. S. Treasury Bonds 2% —1942/54

These bonds were inspected by us at your safe deposit vault. We understand that this fund is an Indemnity Defense Fund and is offset by a like amount under "Liabilities and Surplus." The Trustees have taken out a malpractice liability policy with Underwriters at Lloyds to protect them against any liability of this fund to the extent of $5.000 for any one case, or a total of $46,000 00. This policy is written for a five-year term, expiring January 15, 1945.

* * *

Liabilities and Surplus

MEMBERS' CONTRIBUTION TO ENDOWMENT FUND —$252.44:

TRUST FUND—$49,708.00:

These items are offset under "Assets" and have been discussed in detail hereinabove.

SURPLUS—$94,491.82:

Changes in this item during the year 1942 are shown in the Balance Sheet.

* * *

Statement of Income and Expense

We have exhibited the Income and Expense in this statement in comparative form for the years 1941 and 1942, together with the increase or decrease in each item. We have satisfied ourselves that the income has been correctly accounted, and that the expenditures have been proper.

Very truly yours,
(Signed) Hood and Strong.

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

San Francisco, California

BALANCE SHEET DECEMBER 31, 1942

ASSETS

CASH		$ 5,999.33
On Deposit — Bank of America, N. T. & S. A.:		
Commercial Account	$ 185.56	
Savings Account	5,813.77	
INVESTMENTS		42,129.42
U. S. Government Securities	42,000.00	
Accrued Interest to December 31, 1942	129.42	
DUE FROM CALIFORNIA MEDICAL ASSOCIATION		46,498.07
ENDOWMENT FUND — Held in Savings Account		252.44
BENEVOLENCE FUND — Held in Savings Account		4,369.30
TRUST FUND		49,708.00
Savings Accounts	12,286.01	
Wells Fargo Bank & Union Trust Co. $6,145.97		
American Trust Co. 6,140.04		
Due from Trustees of the California Medical Association	135.00	
Due from California Medical Association	137.50	
U. S. Government Securities	37,000.00	
Accrued Interest to December 31, 1942	149.49	$148,956.56

LIABILITIES AND SURPLUS

DUE TO INDEMNITY TRUST FUND		$ 135.00
MEMBERS' CONTRIBUTION TO ENDOWMENT FUND		252.44
TRUST FUND		49,708.00
BENEVOLENCE FUND		4,369.30
SURPLUS		94,491.82
Contributed Surplus:		
Received from California Medical Association	$75,000.00	
Earned Surplus	19,491.82	
Balance, January 1, 1942 $18,025.33		
Net Income for Year ended December 31, 1942 1,466.49		$148,956.56

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION) AND CALIFORNIA MEDICAL ASSOCIATION

San Francisco, California

COMBINED BALANCE SHEET DECEMBER 31, 1942

	TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION	CALIFORNIA MEDICAL ASSOCIATION	ELIMINATIONS	COMBINED DECEMBER 31, 1942	COMBINED DECEMBER 31, 1941	INCREASE *Decrease*
ASSETS						
Cash	$ 5,999.33	$32,765.92		$ 38,765.25	$ 50,146.35	*$11,381.10*
Marketable Securities	42,129.42			42,129.42	42,129.42	
Due from California Medical Association	46,498.07		46,498.07			
Accounts Receivable		1,629.36		1,629.36	1,641.01	*11.65*
Endowment Fund	252.44			252.44	245.64	6.80
Benevolence Fund	4,369.30	2,141.50		6,510.80	6,870.64	*359.84*
Trust Fund	49,708.00	1,155.49		50,863.49	50,202.15	661.34
Furniture, Equipment, etc.		1.00		1.00	1.00	
Deferred Charges		891.37		891.37	1,189.54	*298.17*
Other Assets		39,300.00		39,300.00	45,243.13	*5,943.13*
	$148,956.56	$77,884.64	$46,498.07	$180,343.13	$197,668.88	*$17,325.75*
LIABILITIES, RESERVES AND SURPLUS						
Due to the Trustees of the California Medical Association		$46,498.07	$46,498.07			
Other Accounts Payable		1,825.15		$ 1,825.15	$ 2,729.33	*$ 904.18*
Due to The Indemnity Defense Fund	$ 135.00	137.50		272.50		272.50
Members' Contribution to Endowment Fund	252.44			252.44	245.64	6.80
Benevolence Fund	4,369.30	2,141.50		6,510.80	6,870.64	*359.84*
Deferred Income		60.00		60.00	4,743.00	*4,683.00*
Trust Fund	49,708.00	1,155.49		50,863.49	50,202.15	661.34
Reserves		39,300.00		39,300.00	40,300.00	*1,000.00*
Surplus	94,491.82	*13,233.07*		81,258.75	92,578.12	*11,319.37*
	$148,956.56	$77,884.64	$46,498.07	$180,343.13	$197,668.88	*$17,325.75*

TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION (A CORPORATION)

San Francisco, California

STATEMENT OF INCOME AND EXPENSE
COMPARATIVE FOR THE YEARS ENDED
DECEMBER 31, 1942 AND DECEMBER 31, 1941

	YEAR ENDED DECEMBER 31, 1942	YEAR ENDED DECEMBER 31, 1941	INCREASE *Decrease*
INCOME:			
Interest on Bonds	$1,546.25	$1,618.87	*$72.62*
Interest on Savings Accounts	106.24	6.27	99.97
	$1,652.49	$1,625.14	$27.35
EXPENSES:			
Audit Fee	$ 130.00	$ 140.00	*$10.00*
Miscellaneous	56.00	30.55	25.45
	$ 186.00	$ 170.55	$15.45
NET INCOME	$1,466.49	$1,454.59	$11.90

REPORT OF THE EXECUTIVE SECRETARY

To the President and the House of Delegates:

Your executive secretary submits his report for the year 1942, breaking the report down into the various divisions of his duties:

1. *General.* The office of the Association has been maintained and operated during the year with due regard for economy and efficiency. The office staff has performed its duties well and has exhibited a spirit of coöperation, in the face of numerous outside opportunities born of the war, that is most gratifying.

2. *Financial.* Financial affairs of the Association were kept under strict surveillance during the year. Total expenditures for the year, exclusive of sums spent on the Basic Science Act, amounted to $80,378, or $14,010 less than the amount budgeted for the year. Revenues of $128,883 were $1,483 above the year's budget. The gain of $14,010 in unexpended budget items, plus the gain of $1,483 in revenues, plus a budgeted surplus of $33,012 for 1942, made it possible for the Association to expend $57,405 on the Basic Science Act with a minimum drain on accumulated surplus funds.

California and Western Medicine was produced for a total expenditure of $26,915, which was $4,688 less than the expenditure for 1941 and $7,535 less than the year's budget.

At the close of 1942 the Association's finances were in excellent condition. Ample reserve funds were on hand for contingencies, expenditures were running well below anticipated levels and revenues were holding up to expectations.

For 1943, prospects are that a balanced budget will be achieved and some surplus accumulated. Membership dues, which were increased for 1943 to offset the loss of dues from members in military service, should reach the budgeted level, and every effort will be made to keep expenditures within the budget allowances. It must be borne in mind that wages, supplies and everything which the Association must purchase have all risen in price. In the competitive war market it is necessary to meet conditions from day to day, always with an eye on the future and on the ultimate aim of the Association. It is the objective of your executive secretary to handle the Association's affairs with these thoughts in mind.

3. *California and Western Medicine.* As mentioned above, your journal was produced in 1942 at a considerable monetary saving over 1941. Out-of-pocket loss for 1942 on the journal was $574, compared with a loss of $4,535 for 1941. Advertising revenues were a little ahead of the 1941 level and are holding up well in 1943.

Production costs of the journal are again increasing, due to higher costs in the paper and printing markets and to a larger subscription list to accommodate the increased membership. It is not likely that the financial showing for 1943 will be as favorable as for 1942. However, due care will be exercised to keep these costs at a fair level.

4. *Annual Session.* Technical exhibits at the 1942 annual session brought in only $15 less than the record high revenue of $7,865 achieved in 1941. Actual revenue from these exhibits was enough to cover the entire cost of the annual session, including the purchase of scientific exhibit equipment, and to leave a surplus of $1,384, which was available for other Association activities.

There will be no technical exhibits at the 1943 annual session.

5. *Procurement and Assignment Service.* The C.M.A. Council has voted consistently to coöperate in all respects with Procurement and Assignment Service and has authorized the executive secretary to devote a part of his time to the work of this service. During 1942 he has followed these instructions and has endeavored to relieve in every way possible the practicing physicians who have volunteered their efforts in this work. California's record of accomplishment in Procurement and Assignment Service has drawn high praise from the officials of the service in Washington.

6. *Public Relations.* The Association has had no defined plan of public relations in the past year but the executive secretary has endeavored to maintain a cordial relationship with newspaper representatives. Several releases on various subjects have been very well received by the press, and the 1942 annual session drew a large volume of favorable newspaper publicity, with no adverse stories.

It is particularly important at this time that cordial relationship be maintained with all newspaper publishers, not only by the C.M.A. office but by the county societies and the individual physicians. So many C.M.A. members are now in military service that efforts will likely be made by other interests to promote legislation adverse to medical interests. With one-third of the C.M.A. members away from home, the obligation on the remaining two-thirds to uphold the best in medical standards has become increasingly important. In this effort the assistance of newspaper publishers and editors is a most valuable adjunct.

7. *Conclusion.* Your executive secretary wants to express here his thanks to the members of the Council and to the officers of the various sections and component county societies for their coöperation during the past year. He stands ready to carry out to the best of his ability such assignments as may be given him in the coming year.

Respectfully submitted,
John Hunton, *Executive Secretary.*

REPORT OF LEGAL DEPARTMENT

To the President and the House of Delegates of the California Medical Association:

Under present condition we have felt it proper to condense this report as much as possible.

Fee Schedule in Compensation Cases.—Since the adjournment of the last annual meeting on May 7, 1942, the most important matter dealt with by this department

has been the fee schedule under the Workmen's Compensation Act.

At the September meeting of the Council, two committees were appointed: one to prepare a revised schedule for presentation to the Industrial Accident Commission, which committee consisted of Drs. Don Cass, Chairman, Frank A. MacDonald and Carl L. Hoag; the second committee was entrusted with the responsibility of presenting the fee schedule to the Commission. This committee consisted of Captain Philip K. Gilman, Chairman, Mr. John Hunton, Executive Secretary, and Hartley F. Peart, General Counsel.

From information obtained from the members of the two committees, the records of the Association, of the Industrial Accident Commission and of the Insurance Commissioner's office and other sources, a petition was prepared, setting forth many reasons why the existing partial fee schedule should be supplanted by a complete and adequate fee schedule affording reasonable compensation to physicians practicing under the Act. As the commission fixed a public hearing (which was held February 15th), and considerable opposition developed among insurance companies and some self-insurers, careful preparation was made for the presentation of the application, and complete statements were taken from members of the committee and other witnesses so as to be ready to support the application with competent testimony. Before this report is published, the text of the application itself and of the closing argument made to the Commission will doubtless appear in CALIFORNIA AND WESTERN MEDICINE.

Wartime Legal Problems.—During the course of the year numerous opinions have been rendered in connection with: the status of members called upon in defense activities, emergency work and military service; the rights of physicians regarding their practices and locations following displacement for civilian work under the Procurement and Assignment Service; rights under office leases upon entering military service; Association membership as a prerequisite to acceptance into Army and Navy service; curfew regulations; malpractice insurance policies with relation to service in the armed forces. We have been called upon to work out the procedure to be followed by doctors on entering military service with respect to narcotic prescription books; to prepare opinions on various phases of operation of blood banks. The usual number of opinions have been rendered on miscellaneous subjects, including an examination of the opinions of the Court of Appeal and the Supreme Court in action brought by the United States against the American Medical Association and others.

County Societies.—Assistance has been rendered one society (Santa Barbara) in the formation of a holding corporation, making suggestions concerning the articles of incorporation, by-laws, etc. A complete revision has been made of the constitution and by-laws for the Placer-Nevada-Sierra County Society.

Legislation.—Activity in this field has been above normal. All bills introduced in the legislature affecting physicians, medical practice and public health have been carefully reviewed for the legislative committee. Amendments have been prepared to a number of bills.

Expediting Licensing Procedure by State Board of Medical Examiners.—Active assistance was rendered the Board in the drafting of a bill to expedite the procedure of the Board in the matter of examinations and licensing without in any manner affecting existing standards.

Throughout the year the other activities of this department have continued as usual.

Respectfully submitted,

HARTLEY F. PEART, *General Counsel.*

REPORT OF THE EDITOR

To the President and the House of Delegates:

During the last year, in its regular issues, CALIFORNIA AND WESTERN MEDICINE has observed the limitation not to exceed 96 pages per issue—approximately 54 of which are text, and the remaining, advertisement pages. Owing to war conditions, it was necessary in 1942 to allocate additional space to the department of the "Committee on Participation of the Medical Profession in the War Effort" and to the many new problems in which the interests of Organized Medicine are involved. As the OFFICIAL JOURNAL of a constituent state medical association, CALIFORNIA AND WESTERN MEDICINE,—as do other State Association publications,—presents to the members of the California Medical Association, month by month, a record of official actions taken by the constituted authorities of the Association, so that members of the component county societies may have a clear understanding of problems confronting the medical profession, not only in local districts and for California, but in other States of the Union. For, today, the interests and future of medical practice go beyond the confines of local areas or the boundaries of a single commonwealth.

Had it not been for the advent of war, it would have been possible for the Editorial Board to have more fully carried out policy procedures adopted by it. As opportunities present, the plans agreed upon will be put into operation.

During the year 1942, departmental material was grouped somewhat as follows:

Editorials	44
Editorial Comment Articles	25
Scientific and General (Original) Articles	75
Case Report Articles	8
Major State Association Committee Reports	123
Major Miscellany Departments	61

The Editor remains under continued obligation to members of the Editorial Board, and to volunteer editorial advisors, who have responded in generous manner when opinions were requested concerning manuscripts.

To contributors —and especially to Doctor W. H. Manwaring for his Editorial Comment articles,—thanks are sincerely given.

Members of the Association are requested to feel free to send in their advices. In-so-far as clerical and other facilities are available, effort will be made to incorporate all worthwhile changes.

Respectfully submitted,

GEORGE H. KRESS, *Editor.*

REPORTS OF DISTRICT COUNCILORS

FIRST COUNCILOR DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties

To the President and the House of Delegates:

The First District doctors have given more medical attention due to the increased population of Southern California. There are many defense plants in this District and it has called for an increase in workers as well as their families.

There have been many doctors leave for military service and this has given us fewer men to do the work and more work to do than in previous years.

The First District societies have all been visited by the Councilor but no State Officers have been able to visit the Societies. The crowding of their professional work has kept them from visiting the various County Societies.

In some of our counties, as many as half the men have gone into service. It requires as many as 50 per cent of our doctors to do the civilian work. The irregulars are having much to do, while the regulars are doing what they can.

There has been no postgraduate work given in the First District due to the stress of the work at home, the inconvenience of traveling and hotel accommodations. The Secretaries' meeting for the year was postponed until another year.

Respectfully submitted,

Calvert L. Emmons, *Councilor,*
First District.

SECOND COUNCILOR DISTRICT

Los Angeles County

To the President and the House of Delegates:

The Councilor, being a member of the Los Angeles Medical Association Council, has kept in touch with the local affairs of Southern California and the Los Angeles Medical Association and there has been a free exchange of ideas with the Council of the California Medical Association and the Council of the Los Angeles County Association. Your councilor feels that there is a mutual coöperation between the county societies and the state societies which is in a very healthy condition at the present time and has been very useful in the Procurement Assignment Service as well as to the Public Health and the Industrial Health and the Public Relations Department of both societies.

I hope very sincerely, that this close coöperation will deepen and become more and more manifest to the remainder of the present emergency, and be possible to expedite many matters which are of interest to both units in a very satisfactory manner.

Respectfully submitted,

Donald Cass, *Councilor,*
Second District.

THIRD COUNCILOR DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura and Inyo-Mono Counties

To the President and the House of Delegates:

There have been many changes in the membership of the component societies of the Third District. Each of the counties has lost many men to the Armed Forces and a few new physicians have come in. So far, there has been no distress in any community due to a shortage of physicians.

There has been no District Postgraduate Course this year, but each society has had interesting and instructive meetings with much stress being placed on the treatment of war casualties. Owing to the size of the District, it is impractical for the Councilor to visit some of the farther societies under existing conditions, but he will attempt to keep in touch with all by mail and telephone.

Respectfully submitted,

H. E. Henderson, *Councilor,*
Third District.

FOURTH COUNCILOR DISTRICT

Fresno, Madera, Kings, Tulare, Merced, Mariposa, Calaveras, San Joaquin, Tuolumne, and Stanislaus Counties

To the President and the House of Delegates:

The usual duties of the Councilor have been performed. About one-third of our members are in the armed services. The remainder are doing a good job caring for the civil population, assisting in defense activities, induction center work, and other activities to promote the war effort. Two localities in the district have reported insufficient medical service.

Due to the great demands on the time and services of our membership, organization problems and affairs have not received merited attention by some of our members. The commendable devotion to duty and public welfare in these days of stress may cause us to neglect our own interests too much.

Respectfully submitted,

A. E. Anderson, *Councilor,*
Fourth District.

FIFTH COUNCILOR DISTRICT

Monterey, San Benito, San Mateo, Santa Cruz, and Santa Clara Counties

To the President and the House of Delegates:

The activities of the current year are coming to a close and will culminate with the annual session at Los Angeles on May 2nd and 3rd. Because of the war, it has been impossible for me to personally contact each of the component Councils of the Fifth District this past year. However, I have acquainted them with the activities of the California Medical Association program, by letter and I have tried to carry the messages of what is going on in C.M.A. to them.

I am proud to say that in this district medical men have responded well to the call to service and our quota has been nearly reached. In only one or two of the districts more thickly populated are there any more available doctors for service.

Some of the counties in the district have seen fit to cancel their regular meeting because of the dimout, and it is difficult for them to meet at night. Most of the counties, however, have maintained their monthly meetings.

There has been keen interest any many inquiries regarding the C.P.S.

We are sorry to report the death of Dr. L. Ruiz who was killed in action at Bataan.

Respectfully submitted,

R. S. Kneeshaw, *Councilor,*
Fifth District.

SIXTH COUNCILOR DISTRICT

San Francisco County

To the President and the House of Delegates:

During the past year, the normal activities of the San Francisco County Medical Society which comprises the Sixth District have been curtailed. Section meetings have been abolished and monthly general meetings substituted.

Medical Civilian Defense has been reorganized and considerably improved with close coöperation between the Office of Civilian Defense and the medical profession. The Special Service Fund has grown but has not reached the anticipated proportions. The Society has made every effort to meet the increasing demands for medical care presented by the growth in population and the influx of strangers.

The Irwin Memorial Blood Bank has continued to render its splendid service both as a Blood Bank and Plasma Procurement Center. Through its efforts, a considerable supply of plasma has been amassed primarily for use by the civilian population.

Climaxing four years of negotiations, the Society has ultimately achieved a satisfactory status with regard to the Health Service System of the municipal employees.

Respectfully submitted,

John W. Cline, *Councilor,*
Sixth District.

SEVENTH COUNCILOR DISTRICT

Alameda and Contra Costa Counties

To the President and the House of Delegates:

As in previous years, your Councilor for the Seventh District has made an earnest effort to keep up proper contacts with the officers and members of the two county societies in his district. Many new problems have come to the front in this area, especially in relation to wartime industry and federal housing conditions. The medical profession in this district has been called upon to consider many serious matters. It is hoped that satisfactory solutions may be found. Your Councilor has been present at meetings of the societies, and also arranged a dinner, with members of the legislature and other public officials present, at which public health and related problems of the district were discussed. It is gratifying to know that the legislative and other officers who attended have a most cordial feeling for members of the medical profession, and in public health policies.

Respectfully submitted,

Frank R. Makinson, *Councilor,*
Seventh District.

EIGHTH COUNCILOR DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter Tehama, Yolo, and Yuba Counties

To the President and the House of Delegates:

Activities in the 8th District have been markedly restricted during the past year on account of war conditions. No postgraduate conference was held due to the reduction in the number of physicians in this district, the excessive distance necessary to travel for such a conference and the restriction on gasoline and tires. For similar reasons the yearly visit of the officials of the California Medical Association was omitted this year. It is hoped that these activities may be resumed during 1943 if improvement in local conditions warrants.

Respectfully submitted,

Frank A. MacDonald, *Councilor,*
Eighth District.

NINTH COUNCILOR DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties

To the President and the House of Delegates:

America at War has changed the amount of time your Councilor has been able to give to visiting the County Medical Societies in the Ninth District. Gas rationing as well as tire rationing made it less desirable to visit distant counties.

It was my pleasure to visit the Napa and Marin as well as the Solano County Societies and help them decide on the type of medical service plans to be put into effect in the Housing Units built to take care of the influx of government workers employed at Mare Island Navy Yard and Marinship.

Up to the present time our judgment to use the facilities offered us by California Physicians' Service has been proven to be sound. The effort to obtain a new, modern hospital for Vallejo has failed to materialize although we have not given up hope so far. We have been grateful to the Auxiliary for their services in this district and hope they continue to be effective each year.

The Council meetings have been constructive and educational to me and have resulted in broadening my viewpoint on many matters.

On account of having to spend many more hours in my office to help look after the illnesses and injuries of Mare Island workers, I have not given the time to the Councilorship that I would have given in normal times.

I wish to thank the County Society officers and members for much help, consideration, and courtesy during the three years it has been my grateful privilege to serve the Ninth District. A new Councilor will be chosen for the years 1943-1944-1945 and I hope my successor may have the same type of coöperation as I have had when he goes into office.

Respectfully submitted,

John W. Green, *Councilor,*
Ninth District.

REPORTS OF COUNCILORS-AT-LARGE

To the President and the House of Delegates:

As one of your Councilors-at-Large, I have attended all regular and special meetings of the Council during the year; have visited the majority of the component societies in the First District; and have endeavored to promote coöperation among the organized groups of the District.

Respectfully submitted,

S. J. McClendon, *Councilor-at-Large.*

To the President and the House of Delegates:

As a Councilor-at-Large of the California Medical Association, I have attended all of the Council meetings to date, and have actively participated in the various meetings, since my election in May of nineteen hundred and forty-two.

Respectfully submitted,

Edwin L. Bruck, *Councilor-at-Large.*

To the President and the House of Delegates:

As one of the six Councilors-at-Large, I have attended Council meetings, and as its chairman have endeavored to carry out the Council's instructions to the best of my ability. Although in active service in the U.S.N.R., my assignment, with office in San Francisco, permitted me to remain in close touch with the C.M.A. headquarter's office.

Respectfully submitted,

Philip K. Gilman, *Councilor-at-Large.*

To the President and the House of Delegates:

During the last year, I have attended all the meetings of the Council, and have actively engaged in all of the deliberations of this body. The year just closed has not presented as many problems for Council action as in former years. Such as have been presented have been diligently studied and my part has been to aid in the adequate dispatch of these problems.

I have made it a point to bring first hand information concerning the affairs of the California Medical Association and California Physicians' Service to many fellow Association members. I have found that there is room for missionary work to clear up misunderstandings and opinion based on misinformation.

Respectfully submitted,
E. Earl Moody, *Councilor-at-Large.*

To the President and the House of Delegates:

During the past year, in my function as a Councilor-at-Large, I have endeavored at all times to consider most carefully the many important problems that have presented themselves for decision, and to arrive at a solution that would be for the best interests of the medical profession as a whole.

I have kept my own San Joaquin County Society fully informed as to the problems of organized medicine and legislative activities, and have, as well, reported on the progress and scope of the California Physicians' Service.

It has been a pleasure to coöperate with the secretary-editor, Dr. George H. Kress, and the executive secretary, Mr. John Hunton, and the members of the Council in their sincere endeavor to wisely solve the many problems before us.

Respectfully submitted,
Dewey R. Powell, *Councilor-at-Large.*

To the President and the House of Delegates:

It has been my privilege to attend all of the Council meetings in the past year, and to keep the members in my locality informed of the problems facing the Association and its membership.

Respectfully submitted,
Edward B. Dewey, M. D., *Councilor-at-Large.*

REPORTS OF STANDING COMMITTEES

EXECUTIVE COMMITTEE

Executive Group

Henry S. Rogers, Chairman
William R. Molony, Sr., President
Karl L. Schaupp, President-Elect
Lowell S. Goin, Speaker, House of Delegates
Philip K. Gilman, Chairman of the Council
John W. Cline, Chairman, Auditing Committee
Henry S. Rogers, Past-President
George H. Kress, Secretary-Treasurer and Editor

To the President and House of Delegates:

The Executive Committee has had very little call on its services in the past year, and has been able to meet most of the demands through the holding of informal meetings and by correspondence.

Departing from the usual custom of holding all Executive Committee meetings in San Francisco, one meeting was held in Vallejo, with the Solano County Medical Society, to discuss with the society the Federal Housing Projects and the best method of providing medical care to the residents of these projects.

Three meetings were held to discuss the disagreement between California Physicians' Service and Hospital Service of California. No settlement could be reached and the Executive Committee authorized a survey of the three Blue Cross Hospital plans in California, hoping by so doing a betterment in medical service and hospitalization plans may be realized.

Respectfully submitted,
Henry S. Rogers, *Chairman.*

AUDITING COMMITTEE

Executive Group

John W. Cline, Chairman, 1943
Edwin L. Bruck, 1943 Frank R. Makinson, 1943

To the President and the House of Delegates:

The Auditing Committee has performed the functions laid down in the by-laws. The professional audit of the Association books showed them to have been accurately kept, and the Committee has submitted its recommendations for the 1944 budget.

Respectfully submitted,
John W. Cline, *Chairman.*

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Executive Group

Dwight H. Murray, Chairman, 1944
Edmund T. Remmen, 1943 Anthony B. Diepenbrock, 1945
President and President-Elect ex officio
Advisory Committee to Above
Junius B. Harris, Chairman
H. R. Madeley, Vice-Chairman

To the President and the House of Delegates:

The following is a report of the activities of your Legislative Committee since the 1942 California Medical Convention at Del Monte.

The Legislative Committee of the California Medical Association, Dentists, Nurses, Dispensing Opticians, Chiropodists, Physical Therapists, Druggists, and Hospital Association, met in July for the purpose of discussing various candidates before the Primary election. They met again in September to discuss the candidates before the November election, and finally in March, 1943, to discuss the various legislative problems pertaining to each group.

During the present session of the Legislature 3,000 bills were introduced, over 600 of which pertained to medicine and public health.

Your Legislative Committee finds itself very busy in following these bills through the various Committees of the Assembly and Senate in order that we may give them proper attention at the right time.

Respectfully submitted,
Dwight H. Murray, *Chairman.*

REPORT OF COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Executive Group

John V. Barrows, Chairman, 1943
Edwin L. Bruck, 1944 Clarence E. Rees, 1945

To the President and the House of Delegates:

The past year has found this committee working entirely separately in its attempt to assist the Medical Association in its relationship to associated societies. Several times the Nurses' Association and the Woman's Auxiliary, together with the Hospital Association, have been contacted in regard to their problems. The committee has had no constructive work of its own but has tried to assist wherever help was needed. We have given

considerable care to the Physicians' Aid Association in helping those members of the Association who, through adversity, are now in need. The State Committee has been most kind and coöperative in coming to our assistance. We urge that the Council and House of Delegates make special effort to urge each member of the Association to give additional means in support of assistance to both the state and local Physicians' Aid Committee.

The nurses' problems have been state-wide, which gives this committee a small chance to assist a great deal. We, however, are ready for whatever work is assigned to us.

We wish to thank the Secretary-Editor, Dr. George H. Kress, for his kindness and extreme helpfulness at all times.

Respectfully submitted,
John V. Barrow, *Chairman.*

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Executive Group

John C. Ruddock, Chairman, 1944
J. C. Geiger, 1943 C. M. Birchfield, 1945

To the President and the House of Delegates:

The members of the Committee on Health and Public Instruction have held no regular meeting during the past year.

Your Chairman is on active duty with the U. S. Navy and is assigned to duty with the Naval Officer Procurement program in the Eleventh Naval District. Your Chairman has been and is closely associated with the Procurement and Assignment Service in the procurement of physicians for military duty. He has attended the various conferences held and assisted in many ways in the proper allocation of physicians both for military and civilian needs. The quota of physicians for the military service in California during 1943 is 1,139 physicians, 761 of which must come from Los Angeles and Orange County; 345 from San Francisco and 33 from the remainder of the state. It is the opinion of the Chairman of the Committee that organized medicine should recognize the needs of filling the quota from California, especially filling the quota with young doctors. The failure to meet this challenge by organized medicine could result in the complete regimentation of the practice of medicine. This is serious and it is recommended that the House of Delegates enact such legislation or pass such measures that will enable the Procurement and Assignment Chairmen to release a young doctor of military age from so-called essential positions, so that he can then become available to the armed forces.

Dr. Wilton L. Halverson, a member of the Committee, formerly Health Officer of Los Angeles County, has now been appointed State Director of Public Health, in which position he becomes director of the medical needs of civilian defense for the State of California.

Respectfully submitted,
John C. Ruddock, *Chairman.*

COMMITTEE ON HISTORY AND OBITUARIES

Executive Group

Morton R. Gibbons, Sr., Chairman, 1944
Hyman Miller, 1943 Robert A. Peers, 1945

To the President and the House of Delegates:

The Committee on History and Obituaries has found itself unable, in the last year, to devote time to accumulation of historical data, because of the overwhelming proportions history in the making is assuming.

California's contribution to the history of the war should be a valuable document. California and Western Medicine, and the Bulletins of County Medical Societies, are gathering personal data and personal experiences which, when compiled, will be exceptional.

Coöperation with the California Historical Society is being developed, and will be of great value in our researches. It is to be hoped that when life becomes normal, there will be clerical assistance available to compile the data now in sight.

A list of the members who have died during the past year is appended. Many suitable obituaries have been published in California and Western Medicine.

Respectfully submitted,
Morton R. Gibbons, Sr., *Chairman.*

In Memoriam

Alameda County

Archibald Addison Alexander (January 17, 1942)
Urban Clark Billingsley (November 15, 1942)
Charles Alfred Dukes (March 13, 1942)
Louis Henry Dyke (June 2, 1942)
Donald Edward Froehlich (April 22, 1942)
Joseph John Gomes (January 8, 1942)
Rossner Enders Graham (October 6, 1942)
Channing Hall (December 14, 1942)
William Almon Wood (July 21, 1942)

Fresno County

Clause Peter Hoyer Kjaerbye (May 6, 1942)

Humboldt County

John Alexander Lane (November 13, 1942)

Inyo-Mono County

Harvey Willis Crook (August 2, 1942)

Lassen-Plumas-Modoc County

Gordon Russell Fortson (July 12, 1942)

Los Angeles County

John Lorin Aird (March 9, 1942)
Oscar Anderson (September 6, 1942)
William Sidney Bowers (September 4, 1942)
Paul Revere Burroughs (July 1, 1942)
Frank Edward Detling (December 25, 1942)
Bertrand Le Roy Ellis (October 31, 1942)
William Clinton Finch (August 10, 1942)
Edward Alfred Franklin (November 4, 1942)
Harley James Gunderson (May 29, 1942)
Giles S. Hall (June 4, 1942)
Harry H. Heylum (October 30, 1942)
Thomas Van Hunter (January 22, 1942)
Jacob Kevork Kelleyan (April 2, 1942)
Floyd James Lee (January 3, 1942)
William Michael Maloney (February 28, 1942)
Samuel Jones Mattison (October 3, 1942)
Clyde Vincent Nelson, Jr. (June 19, 1942)
Clyde Amandee Noland (October 24, 1942)
Joseph Raymond Perry (July 7, 1942)
Harry Andrew Shafor (May 27, 1942)
Hobart Parker Shattuck (December 10, 1942)
Homer Waldo Spiers (July 10, 1942)
Andrew Fremont Wagner (March 28, 1942)
Fred V. Watson (January 6, 1942)
William Taylor Webber (March 26, 1942)
Percival Gordon White (April 28, 1942)
M. Russell Wilcox (March 25, 1942)

Orange County

Wayne Adelbert Harris (November 25, 1942)

Placer-Nevada-Sierra County

Clarence Quinan (December 8, 1942)
Alfred H. Tickell (January 28, 1942)

Riverside County

Alexander Barclay (February 27, 1942)

Sacramento County

Joseph Dillon, Jr. (December 6, 1942)
Frederick F. Gundrum (October 23, 1942)
Frank Edward McCullough (June 4, 1942)

San Bernardino County

Donald Stanley Gidley (July 5, 1942)

San Diego County

Vernon Greene Clark (June 6, 1942)
Rubin Ora Hoffman (August 16, 1942)
Carl Shuey Owen (October 18, 1942)
Ernest Boring Porter (November 16, 1942)

San Francisco County

James Joseph Hogan (July 14, 1942)
Eugene Sterling Kilgore (January 2, 1942)
Eric Liljencrantz (November 5, 1942)
Ernest Lohnberg (February 14, 1942)
Lionel David Prince (March 6, 1942)
Edmund Haughton Sawyer (November 17, 1942)
Alfred Baker Spalding (November 25, 1942)
Thomas Albion Stoddard (April 7, 1942)

San Joaquin County

Louis Montrose Haight (April 26, 1942)
Ellis Harbert (July 16, 1942)
James Everett Nelson (January 5, 1942)

Santa Barbara County

Lawrence Frank Eder (October 11, 1942)

Santa Clara County

Charles Shattinger (December 13, 1942)

Santa Cruz County

Howard Charlels Crum (July 29, 1942)

Solano County

Francis Stolle (December 19, 1942)

Sonoma County

Bayley Burton Bachelder (February 25, 1942)

Stanislaus County

Charles E. Pearson (May 23, 1942)

Ventura County

Francis Royal Hendricks (December 27, 1942)

Yuba-Sutter-Colusa County

Thomas Edward Larner (July 4, 1942)

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Executive Group

J. Norman O'Neill, Chairman, 1945
Benjamin W. Black, 1943 Walter Rapaport, 1944

To the President and the House of Delegates:

Last year's report with reference to the hospital situation is still in the pending stage as no decision has been made on taking pay patients into county hospitals, particularly is this true regarding the Los Angeles County Hospital.

It has, however, been determined that the County Hospital cannot refuse cases which cannot be entered in the private institutions, and the county authorities will take these cases as emergency cases. The private hospital situation is now at the point where some of these cases are appearing at the County Hospital. The hospitals in Southern California and the County Medical Association are now studying the matter. From this study will probably come a suggested plan for the private hospitals to lease a certain portion of the County Hospital's vacant beds in order to admit pay patients under the sponsorship of the private hospitals.

The hospitals in the City of Los Angeles will also inaugurate a campaign for capital funds in order to increase the hospital facilities in the city. This campaign will be conducted in the month of May, 1943, and has as its goal three million dollars. A portion of these funds will be used for immediate expansion of private hospital facilities not involving new construction. The balance of the money will be set aside for a capital building fund as soon as the necessary priorities can be secured for such construction.

The hospitals of the State of California have also been in considerable litigation with the State Employment Commission concerning their rulings applying the State Unemployment Tax to nonprofit hospitals. This has been well covered by certain articles in the California and Western Medicine. It is being reported at this time in order that physicians may acquaint themselves with the problem as it is important that the present tax exemption status for nonprofit hospitals should continue in order that all the funds of these nonprofit charitable organizations may be conserved for vital service to the sick and injured.

The hospitals in the State of California are doing an excellent job in the organization of emergency service under Civilian Defense in the establishment of necessary blood and plasma banks and in carrying out a program designed to be in readiness-to-serve should disaster occur.

The problems facing hospitals have been augmented by the war effort, due to the increased cost of supplies, rationing of supplies, and the shortage of labor. The shortage of nurses has created a demand by the State Nurses' Association for higher salaries. The minimum wage for general duty nurses has increased from $125 to $140 per month on November 1, 1942. This increase alone affected the cost to the patient approximately $1.00 per patient per day. Certain information is now being circulated by the California State Nurses' Association requesting that the members of the State Nurses' Association allow their Board of Directors to be their bargaining agent, proposing bargaining contracts with hospitals and proposing a new minimum wage of $155 per month. We believe that it is important that the medical profession watch the trend, particularly of the apparent transition of a professional organization to a closed shop bargaining union. This may have a tendency to destroy some of the splendid standards of our voluntary institutions.

The cost factor is also an important item, as for years California, because of taxes, minimum wage laws, etc., has had the highest hospital costs in the nation. The present drastic increases may put private hospitalization beyond the pocketbooks of many persons and may be an incentive for additional demands for the socialization of hospitalization.

Respectfully submitted,

J. Norman O'Neill, *Chairman.*

COMMITTEE ON INDUSTRIAL PRACTICE

Executive Group

Donald Cass, Chairman, 1945

George H. Sanderson, 1943 Wilbur J. Cox, 1944

To the President and the House of Delegates:

There has been no meetings of the Industrial Practice Committee this year. There has been some correspondence conducted between the chairman of the committee and the committee on industrial practice of the American Medical Association.

As reported in our last year's report to the Council and to the House of Delegates, we believe that a revamping of the Committee on Industrial Practice would be a good plan so as to include industrial hygienists and possibly closer coöperation with the California State and the local County Board of Health who are interested in this industrial matter.

This is a matter which has been under advisement, I understand by the council of the C M A., but further reports by the Committee of Industrial Practice does not show any definite new business.

Respectfully submitted,

Donald Cass, *Chairman.*

COMMITTEE ON MEDICAL ECONOMICS

Executive Group

Glenn F. Cushman, Chairman, 1944

Edward C. Pallette, 1943 C. A. Broaddus, 1945

To the President and the House of Delegates:

Wartime changes have brought to the fore much discussion concerning social welfare problems. Plans for State supervision of health of citizens continue to receive much attention. It is important that members of the medical profession remain alert regarding these discussions. Times such as the present offer special opportunities for the proponents of theories who espouse so-called state and socialized medicine, to advance consideration of their respective procedures. Medical practice as now existent in the United States has proved its worth. Its methods should not be lightly cast aside. New plans must receive earnest consideration.

Respectfully submitted,

Glenn F. Cushman, *Chairman.*

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSITUTIONS

Executive Group

B. O. Raulston, Chairman, 1944

Fred H. Kruse, 1943 L. R. Chandler, 1945

To the President and the House of Delegates:

Through several articles which have appeared in California and Western Medicine during the last year, under the name of the Committee on Medical Education and Medical Institutions, attention was called to the accelerated courses brought into being through directives from the federal authorities. The four medical schools of California have arranged their curricula to be in harmony therewith, and each institution is using its best endeavors to promote the proper training of medical matriculants. It is gratifying to know that the changes that have been inaugurated will lead to no deterioration in educational standards.

Respectfully submitted,

B. O. Raulston, *Chairman.*

COMMITTEE ON MEDICAL DEFENSE

Executive Group

Nelson J. Howard, Chairman, 1944

Lewis T. Bullock, 1943 R. Stanley Kneeshaw, 1945

To the President and the House of Delegates:

The chairman of the Committee on Medical Defense carried out an active correspondence with both the other members of this same committee and with the Secretaries of the constituent county medical societies of the State of California during the year 1941-42. An effort was made to have each society establish a Medical Grievance Committee and a Professional Conduct Committee, with an active personnel and a strenuous effort was made to persuade each county medical society to change its by-laws to conform with the "New Haven Plan of Medical Defense," as outlined in the California Medical Association brochure on Medical Defense, published by the Association in 1936. The efforts of this committee, ably seconded by the personal efforts of Mr. John Hunton, met with a qualified success.

A second objective of the committee on medical defense was an effort to place medical malpractice insurance with sound reliable insurance carriers, and to transfer, if possible, such insurance to domestic carriers. It is the feeling of the chairman of this committee that the only sound coverage is all inclusive liability coverage, and if such concept can be established among the members of our Association, domestic United States insurance carriers can be persuaded to reënter the malpractice field in California. It would be to the advantage of the Association to have an agreement with such a carrier that would enable the Association to make independent actuarial surveys of the malpractice claim records of such a carrier, so that the premiums for malpractice insurance could be periodically adjusted up or down, depending upon the risk experience.

At the May, 1942, meeting, the representative of a domestic carrier was present and willing to present such a program to either the House of Delegates, or to the State Council. This committee neither recommended that the program of the carrier, or that its representative be accepted, but did feel that a discussion of the problem would take place. Nothing satisfactory evolved in any manner of progress.

Respectfully submitted,

Nelson J. Howard, *Chairman.*

COMMITTEE ON PUBLICATIONS

Executive Group

George W. Walker, Chairman, 1943

F. Burton Jones, 1944

Francis E. Toomey, 1945 George H. Kress, ex-officio

To the President and the House of Delegates:

Travel restrictions making it difficult, the Publications Committee has had no meetings since the one at Del Monte last year, much of the work formerly done by the Committee is being carried out by the Executive Committee of the Editorial Board. The by-laws suggest, however, that the Committee on Publications aid in an advisory capacity on all printed literature.

Respectfully submitted,

G. W. Walker, *Chairman.*

COMMITTEE ON POSTGRADUATE ACTIVITIES

Executive Group

G. D. Delprat, Chairman, 1943
Fred B. Clarke, Vice-Chairman, 1944
Frank A. MacDonald, 1945
George H. Kress, Secretary, ex-officio

To the President and the House of Delegates:

Opportunities to present postgraduate and after-graduation courses and clinics steadily diminished after December 7, 1941, because the increased work thrown upon physicians in civilian practice gave little time for local or district meetings of one or two days' duration.

In lieu of such courses, the Committee on Postgraduate Activities agreed that it could best carry on its functions by sending medical literature to the almost one hundred Army, Air Force and Naval Hospital Stations which have come into being in California. Some of these camps have medical personnels of considerable number. In many places, however, and especially in stations away from the metropolitan centers, medical library facilities were almost entirely lacking in these Station Hospitals.

In coöperation with the medical libraries of Stanford University, University of California and Los Angeles County Medical Association, some hundreds of duplicate volumes were divided into small allotments and forwarded to designated hospital stations, in care of the Medical Officer in Command, for use by the medical personnel. Also, hundreds of medical journals received by the Committee from members of the Association were similarly distributed. Each of the hospital stations in California was placed on the mailing list of CALIFORNIA AND WESTERN MEDICINE. These activities were carried on by the Association Secretary, Dr. Kress, who acts as the executive member of the Committee on Postgraduate Work.

The work is still going forward. Letters of appreciation from military colleagues for the service so rendered have appeared in the OFFICIAL JOURNAL. Your Committee will use its best endeavors to render continued service.

Respectfully submitted,

G. D. Delprat, *Chairman.*

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Executive Group

Lewis A. Alesen, Chairman, 1944
L. H. Redelings, 1943 J. H. Doughty, 1945

To the President and the House of Delegates:

Because of conditions brought about by the military situation focusing attention upon units of organized medicine as indispensable in its scheme to supply the best possible medical care to armed forces and civilians alike, we have for some time past, been enjoying what might be appropriately termed a "seller's market" with respect to membership. Under these circumstances there is no need to solicit applications from prospective members but the need is rather to make sure that those who do apply will make the right kind of members when elected.

The Committee on Membership and Organization has held no meetings during the past year. Only one matter of minor importance was presented for its consideration and this matter was happily solved to the satisfaction of all concerned.

It is gratifying to note how willingly both military and civilian authorities look to the local county medical units for leadership and guidance in all matters relating to health whenever and wherever those units assert themselves with an aggressive, constructive and comprehensive program. No opportunity should be overlooked to place organized medicine in a favorable light by any and every legitimate means.

Respectfully submitted,

L. A. Alesen, *Chairman.*

County Society membership totals are given in the appended list:

C.M.A. County Society Membership Totals For Year 1942

Counties	*Year 1941*	*Year 1942*
Alameda County	577	601
Butte-Glenn Counties	41	37
Contra Costa County	57	55
Fresno County	144	151
Humboldt County	34	37
Imperial County	28	26
Inyo-Mono Counties	9	11
Kern County	68	69
Kings County	21	21
Lassen-Plumas-Modoc Counties	18	18
Los Angeles County	2718	2826
Marin County	47	50
Mendocino-Lake Counties	30	29
Merced County	36	35
Monterey County	66	72
Napa County	35	40
Orange County	124	123
Placer-Nevada-Sierra Counties	41	43
Riverside County	78	76
Sacramento County	167	173
San Benito County	6	8
San Bernardino County	159	164
San Diego County	300	334
San Francisco County	1032	1124
San Joaquin County	113	115
San Luis Obispo County	27	29
San Mateo County	87	88
Santa Barbara County	117	123
Santa Clara County	210	228
Santa Cruz County	45	46
Shasta County	19	27
Siskiyou County	17	17
Solano County	37	45
Sonoma County	65	68
Stanislaus County	46	50
Tehama County	10	8
Tulare County	51	48
Ventura County	53	53
Yolo County	24	27
Yuba-Sutter-Colusa Counties	25	26
Total Membership	6782	7121

Deceased Members.—71 members died during 1942. (Included in the above.)

Members in Military Service.—1482 members were in military service on December 31, 1942. (Included in the total of 7114.)

COMMITTEE ON PUBLIC RELATIONS

Executive Group

Donald Cass, Chairman

John Ruddock, Chairman, Committee on Health and Public Instruction

J. Norman O'Neill, Chairman, Committee on Hospitals, Dispensaries, Clinics

Donald Cass, Chairman, Committee on Industrial Practice

Nelson J. Howard, Chairman, Committee on Medical Defense

Lewis A. Alesen, Chairman, Committee on Membership and Organization

Glenn Cushman, Chairman, Committee on Medical Economics

Dwight H. Murray, Chairman, Committee on Public Policy and Legislation

Dwight L. Wilbur, Chairman, Committee on Postgraduate Activities

Harold Brunn, Chairman, Cancer Commission

William R. Molony, Sr., President of California Medical Association

Karl L. Schaupp, President-Elect

George H. Kress, Secretary

To the President and the House of Delegates:

There have been no formal meetings of the Committee on Public Relations since the last convention. Inasmuch as practically all of our public relations business has been undertaken by the executive secretary, the functions of the Public Relations Committee has dwindled to practically none.

The Basic Science Law which was defeated, not through any omission or error in commission on the part of the Committee on Public Relations, but was due rather to an unprecedentedly strong attack made on us by the osteopathic and allied irregular practitioners who spent much more money in opposing this bill than we had anticipated they could collect. In fact, our figures would indicate that the opposition to the Basic Science Law was very expensive and was the cause of its being defeated.

Other public relation functions in the California Medical Association are in the hands, now, of the committee on Procurement Assignment and other agencies which have practically put the Committee on Public Relations on the shelf.

Respectfully submitted,
Donald Cass, *Chairman.*

COMMITTEE ON PUBLIC HEALTH EDUCATION

Executive Group

Frank R. Makinson, Chairman

P. K. Gilman	Thomas A. Card
Samuel Ayres, Jr.	Lowell S. Goin
J. Frank Doughty	Dwight H. Murray

To the President and the House of Delegates:

Your Committee on Public Health Education begs leave to present herewith its final report concerning the much discussed special assessment of ten dollars levied in 1939, whereby the special Committee on Public Health Education was brought into being. Members who wish to refresh their memories can find references in California and Western Medicine, issue of July, 1939 (House of Delegates action, re Substitute Resolution No. 6, on page 437 and Council action, under Item II, on page 446).

Three paragraphs from the Substitute Resolution No. 6 of the House of Delegates follow:

Whereas, The education of the public and public officials in those things which concern the public health and welfare, the standards of the scientific practice of medicine, must be conducted on a wide basis by those who are most qualified to carry on such an educational program; therefore be it . . .

Resolved, That all moneys collected under and pursuant to this resolution shall be carried in a special fund and used only for the educational purposes contemplated in this resolution; and be it further . . .

Resolved, That any moneys remaining in this special fund at such time as the House of Delegates shall discharge this committee, and its work discontinued, shall be properly allocated and returned to those members from whom they have been collected.

Last year's report of your Committee appeared in the April, 1942, issue of California and Western Medicine, on page 220. To that and previous reports, the following brief summary may be appended:

The total number of C.M.A. members who paid the special assessment was 4,933.

Total number of C.M.A. members who failed to pay the assessment is 1,082. During the year 1942, none of the 1,082 nonpaying members paid the assessment.

The total amount collected was $49,330.00.

On January 1, 1943, the sum of $7,189.72 remained to the credit of the special assessment fund, and on December 1st of the same year, the amount remaining was $899.39.

On date of February 19, 1943, a check drawn against the fund liquidated its entire balance.

In compliance with the provisions of Substitute Resolution No. 6 which brought the special assessment into being, the work of the Special Committee on Public Health Education is completed and the House of Delegates is so informed.

For the information of members, it may be stated that the money expended since the last report was rendered, was used largely in promotion of efforts to disseminate public health information and to aid in the enactment of the Basic Science law.

The chairman of your Committee regrets that illness will prevent his attendance at the annual session to give a personal account of the Committee's stewardship.

Respectfully submitted,
Frank R. Makinson, (K), *Chairman.*

COMMITTEE ON SCIENTIFIC WORK

Executive Group

George H. Kress, Chairman, ex-officio

Fletcher B. Taylor, 1943	Howard F. Mast, 1945
J. Homer Woolsey, 1944	

Mast Wolfson, ex-officio (for Medicine)
J. Norton Nichols, ex-officio (for Surgery)

To the President and the House of Delegates:

War and its uncertainties were responsible for the delay in handing down the decision on whether the California Medical Association would hold an annual session in the year 1943. However, after due consideration of all the factors involved, the Council authorized a two-day, streamlined session, commencing not as heretofore on a Monday, but on Sunday.

The Committee on Scientific Work deemed it best to arrange for three general meetings. The twelve Scientific Sections were requested to hold their scientific and business meetings on Monday afternoon. The programs of the three general meetings, prepared by your Committee on Scientific Work, and those of the twelve scientific sections, submitted by the Section Officers, appear in the current issue of California and Western Medicine. Perusal of the same shows that topics having relation to military medicine and wartime needs have been stressed.

The Committee voted to call to the attention of the House of Delegates, the lack of a Section in which colleagues who are public health officials would have opportunity to better present their work. The plan of extending the scope of the "Section on Industrial Medicine and Surgery," through change of name to "Section on Preventive and Industrial Medicine and Public Health," as has been done by the similar section of the American Medical Association, received the Committee's approval. In this year's program, we are indebted to the Western Association of Industrial Physicians and Surgeons for its courtesy in being willing that invitations as guest-speakers to the California Medical Association be extended to two of its own guest speakers.

Our Committee expresses its appreciation to the Regional Medical Officers through whose coöperation it has been possible to secure the services of the colleagues from the Medical Corps of Army and Navy to discuss topics on military medicine, as well as furnish military exhibits and films, with military personnel in attendance.

Thanks are also expressed to Officers of the Scientific Sections, who this year have found the work of securing essayists for their respective programs, anything but easy tasks.

Your Committee begs leave to voice the opinion that, even in times such as the present, it is important that the scientific activities of Organized Medicine be continued, even though only in streamlined, two-day meetings such as this year's annual session will present.

Respectfully submitted,
George H. Kress, *Chairman.*

EDITORIAL BOARD

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Dwight L. Wilbur, San Francisco

Executive Committee:
Dwight L. Wilbur, San Francisco, Chm.
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Albert J. Scholl, Los Angeles
George W. Walker, Fresno

Anesthesiology:
Charles F. McCuskey, Glendale
H. R. Hathaway, San Francisco

Dermatology and Syphilology:
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Clarence J. Berre, Los Angeles
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John D. Gillis, Los Angeles

Plastic Surgery:
George W. Pierce, San Francisco
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Neuropsychiatry:
John B. Doyle, Los Angeles
Olga Bridgman, San Francisco

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles
Daniel G. Morton, San Francisco

Pediatrics:
William A. Reilly, San Francisco
William W. Belford, San Diego

Pathology and Bacteriology:
Alvin J. Cox, San Francisco
R. J. Pickard, San Diego

Radiology:
R. R. Newell, San Francisco
Henry J. Ullmann, Santa Barbara

Urology:
Lewis Michelson, San Francisco
Albert J. Scholl, Los Angeles

Pharmacology:
M. L. Tainter, San Francisco
Clinton H. Thienes, Los Angeles

To the President and the House of Delegates:

In spite of increased professional work devolving on members of the Editorial Board who remain in civilian practice, the general plan of procedure in which the Executive Group passes on all manuscripts submitted, was carried through during the last year. Individual members of the Board who were called upon to express opinions concerning papers in their respective specialties have rendered excellent coöperation, and thanks are expressed for the aid so given.

The limits to the size of California and Western Medicine and the large amount of space needed for war effort activities and work of organized medicine, has not permitted the publication of many good papers. In this, however, the Official Journal suffers as do other medical publications.

Owing to his entrance into military service, it was necessary for the Chairman of the Editorial Board to present his resignation. The Executive Group has outlined general policies which will be carried through by the Editor, in-so-far as existing conditions make possible.

Respectfully submitted,

Dwight L. Wilbur, (K), *Chairman.*

COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT

PROCUREMENT AND ASSIGNMENT SERVICE
Executive Group

Harold A. Fletcher, San Francisco
Chairman for Northern California

Edward M. Pallette, Los Angeles
Chairman for Southern California

To the President and the House of Delegates:

At the onset of war conditions, the California Medical Association, in common with other constituent state medical societies, appointed a State Committee on Medical Preparedness, with committees of similar name and function to represent each of the component county medical societies. These groups carried on much work in connection with Selective Service. Later, on advices from the Washington advisory council, the State and County Committees were continued under the name, "Committees on Participation of the Medical Profession in the War Effort."

When Procurement and Assignment Service was organized, it was decided to permit the committees previously functioning in the work to continue their activities under the supervision of the Procurement and Assignment Service officers appointed by the Washington authorities.

This present report is essentially a report of the Procurement and Assignment Service brought down to date. Reports of work by the "Committees on Participation of the Medical Profession in the War Effort," and of the prior "Committees on Medical Preparedness" appeared month by month under those captions, in the official journal, California and Western Medicine.

During 1942, the Northern California and Southern California offices of Procurement and Assignment Service surveyed the complete medical roster of California, classified every physician in the state and coöperated in the recruitment of approximately 2,400 medical officers for service in the Army, Navy, Public Health Service and other Government departments.

For 1943, we have a program of another 1,139 recruitments, to come mainly from the San Francisco and Los Angeles metropolitan areas. This is a big order and one that will require the complete coöperation of all physicians in California. In general, every physician 45 years of age or under will necessarily be considered available for military duty unless he is in some specific position where his services are vital to the prosecution of the war effort and where he cannot be replaced. The war is no respecter of financial status or obligations, and Procurement and Assignment Service, which is a direct subdivision of the War Manpower Commission, must take into account in its findings the requirements of the military forces for medical officers. This will mean hardships in some cases, hardships which can only be balanced against the potential hardships which can easily be visualized if this country does not win the war.

The work of Procurement and Assignment Service in the past year has not been an easy task. Organization of the two California offices, one for the northern portion of California, and the other for the fourteen southern counties, was slowed down by departmental changes in the Government affiliation and by the difficulty of securing adequate and competent office assistants. However, these obstacles have now been overcome and the offices are functioning smoothly. Meanwhile, the aid of the Council of the California Medical Association in financing necessary operations has been invaluable. Without this help the offices could not have done their work in a manner approaching efficiency. The coöperation of

the C.M.A. office has been always available and of great help.

To Edward M. Pallette, Vice-Chairman for Physicians, and to Henry S. Rogers, R. Stanley Kneeshaw, George Ebright, Clinton D. Collins and Albert M. Meads, members of the California committee, the most profound thanks are due. Without the wise counsel and generous assistance of these men, Procurement and Assignment Service could not have attained the status given it by one member of the Directing Board, who has written that "nowhere in the country is there a better job being done for Procurement and Assignment Service than you are doing in California."

Respectfully submitted.

Harold A. Fletcher, *Chairman.*

COMMITTEE ON LOCAL ARRANGEMENTS

Executive Group

L. A. Alesen, Chairman

B. R. Dysart — William R. Molony, Jr.
Ralph B. Eusden — A. R. Robbins
George H. Kress, ex-officio

To the President and the House of Delegates:

The Los Angeles County Medical Association is happy to act as host to the California Medical Association at its 72nd Annual Session to be held at the Biltmore Hotel on May 2 and 3, 1943.

Borrowing a paragraph from the report of our good friend Mast Wolfson and his colleagues of Monterey, who extolled the many virtues of the Del Monte Peninsula, we regret that present circumstances make it impossible for our committee to demonstrate the obvious advantages of Los Angeles to those who are interested in scenery, recreation, pulchritude, or any other pastime. The Committee's efforts are necessarily concentrated upon making the most of the short, stream-lined, two-day session. The President's Dinner to be held in the Biltmore Bowl on the evening of Sunday, May 2nd, will be the focal point of entertainment at this year's session.

The Biltmore Hotel is conveniently located and its rooms provided for the convention meetings are ample and well situated. The hotel management has been most coöperative in assisting us to help you profit most from this intensified review of the California Medical Association at war.

Respectfully submitted,

L. A. Alesen, *Chairman.*

COMMITTEE ON PHYSICIANS' BENEVOLENCE

Executive Group

Axcel E. Anderson, Chairman

Elizabeth M. Hohl — Robert A. Peers

To the President and the House of Delegates:

At the meeting of the House of Delegates a year ago an amendment to the by-laws of the C.M.A. to permit the allocation of one dollar per active member from the annual dues to the Benevolence Fund was defeated because it was assumed by the reference committee it would result in tying up too much of the income of the C.M.A.

No money has been appropriated by the Council for 1943, but the 1944 budget was voted an allocation of $5,000.00 for the Benevolence Fund.

The Los Angeles County Physicians' Benevolence Association is continuing to care for a large number of needy and has had only a little help from our Fund in their efforts to supplement public charity.

Your committee will make the required report to the House of Delegates and detail expenditures, and ask for instructions on questions of policy as to how much aid we propose to provide and methods of securing funds.

Respectfully submitted,

A. E. Anderson, *Chairman.*

REPORT OF DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates		*Alternates*
Dwight L. Wilbur....	(1942-1943)	L. R. Chandler
Lyell C. Kinney.....	(1942-1943)	 Ben O. Adams
Lowell S. Goin	(1942-1943)	Roy E. Thomas
Henry S. Rogers	(1942-1943)	Philip K. Gilman
Edward N. Ewer	(1943-1944)	...Frank R. Makinson
Edward M. Pallette, Sr.	(1943-1944)	William H. Kiger
Robert A. Peers.....	(1943-1944)	.Frederick N. Scatena
William R. Molony, Sr.	(1943-1944)	 Ralph B. Eusden

To the President and the House of Delegates:

The 1942 Session of the American Medical Association was held in Atlantic City, New Jersey. The attendance was unusually large in spite of the activities incident to the war.

Large crowds were attracted to the Scientific and Commercial Exhibits which were displayed to advantage in the immense convention hall. The Scientific Exhibit improves and grows from year to year and is probably the great attraction that draws the medical men from all parts of the country. It has been remarked by many that the Scientific Exhibit is probably the most valuable asset of the meeting and by itself amply repays the time and money spent in making the trip.

California was well represented and our members presented a very creditable array of exhibits.

The House of Delegates, which is the legislative and governing body of the Association, was in session for four days beginning June 8, 1942. All members of the California delegation, represented by Edward N. Ewer, Lowell S. Goin, Lyell C. Kinney, William R. Molony, Sr., Edward M. Pallette, Robert A. Peers, Dwight L. Wilbur, and George H. Kress, were present and took an active part in the proceedings.

Of the twelve reference committees, Californians were appointed on three, namely: Edward M. Pallette on the Committee on Amendments to Constitution and By-Laws, William R. Molony, Sr., Committee on Reports of Board of Trustees and Secretary Lowell S. Goin on Board of Tellers.

Dr. Dwight L. Wilbur submitted at the request of the California Medical Association a resolution on Rebates. This resolution created quite a stir and was approved in principle by the reference committee and adopted by the house. The Secretary was instructed to send a copy to each state and county society.

Dr. Lyell C. Kinney submitted a resolution on Improvement of Relations between Physicians and Insurance Companies. This resolution was approved.

The Committee on Medical Preparedness submitted its report and was discharged with thanks. In its place was created the War Participation Committee to which was intrusted the study and consideration of all matters which concerned the doctor and the war. Of the five members of the committee, to California came the appointment of William R. Molony, Sr.

Procurement and Assignment was the important topic of discussion, and very important papers and addresses were given to the Delegates by representatives of the Army, Navy, Public Health and Procurement and Assignment Service. Mr. Paul McNutt addressed the House of Delegates on the purposes and objectives of the Procurement and Assignment Service and expressed his satisfaction with the splendid job done by the American Medical Association. He again spoke on the same subject at the dinner given on Monday evening to the members of the House of Delegates by the Medical Society of the State of New Jersey.

Many medical men in the armed services were present in their uniforms which gave a military tone to the meeting.

The highlight of the meeting, as far as California was concerned, was the election of Dr. Edward M. Pallette as Trustee. Not since the days of Phil Jones and Bert Ellis has California been represented on the Board of Trustees. The importance of the Pacific Coast and the personal popularity of Dr. Pallette made possible his election over the strongest kind of opposition. The California delegation was justly proud of the honor that finally came to the Golden State.

The Atlantic City meeting will probably be the last to be held until the war is over. In the meanwhile the House of Delegates will meet each year and California will be there. Had an annual session been held in 1943, the place of meeting would have been San Francisco. It is hoped that the first A.M.A. meeting to be held will convene in that city.

Respectfully submitted,

William R. Molony, Sr.

CANCER COMMISSION

Executive Group

Harold Brunn, Chairman, 1943
Lyell C. Kinney, Vice-Chairman, 1943
Otto H. Pflueger, Secretary, 1943
Orville N. Meland, 1944 — Gertrude Moore, 1944
A. Herman Zeiler, 1944 — Alson R. Kilgore, 1945
Henry J. Ullmann, 1945
Clarence J. Berne, Secretary for Southern Section, 1945

To the President and the House of Delegates:

The passing of Dr. Charles A. Dukes was a great shock to all of us, and the Cancer Commission lost a valuable worker. Our Secretary, Dr. Otto H. Pflueger, has entered the Service, as have many of those men interested in cancer work. The war has actually modified all the activities of the Cancer Committee, although an effort has been made to keep the framework together. It is a question whether it is desirable to hold Microscopic Pathological Conferences on Cancer during the war period.

Members of the Cancer Commission have continued to act as the Executive Committee for the Women's Field Army of the American Society for the Control of Cancer. Mrs. Joseph L. Gould is now head of this organization and has been a very active worker. She has given much time and thought to her duties and has interested a great number of very important people in the cancer program. A large lunch meeting was held by the Field Army and the members of this committee on February 16th, at which time a very interesting discussion was had on the problems involved and the ways and means to make this work felt in the community. We must compliment Mrs. Gould upon her activities and upon her valued advice.

Respectfully submitted,

Harold Brunn, *Chairman.*

CALIFORNIA PHYSICIANS' SERVICE*

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C. Kelly Canelo, M.D.....Vice-President
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John J. Smith, M.D.
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A. W. Warnock, M.D.
Allan R. Watson, M.D.
Dr. Ray Lyman Wilbur
O. T. Wood, M.D.
J. S. Woolford, M.D.

To the President and House of Delegates:

Inasmuch as activities of California Physicians' Service during the recent months are of considerable significance to the medical profession in California, we feel that a résumé covering the period since the meeting of the C.M.A. Council in Los Angeles in September of 1942 is advisable.

You will remember that at the September meeting of the Council, the Medical Director of C.P.S. requested the sponsorship and approval of the Council for certain proposed activities, and reported regarding decisions of the Board of Trustees to make certain changes in C.P.S. contracts.

At this time, approximately 55 per cent of the total membership under the so-called *"full coverage" contract* has been converted to the new two-visit deductible style. The program is continuing, and at the present rate of progress it should be complete by not later than June, at the outside. The effects of this change are already noticeable, even though the months of service which have been reviewed are in the early stages of the change. We receive a smaller number of bills each month, and the treatments reported are for more serious illnesses, instead of the minor complaints which formerly consumed such a large proportion of our funds.

It is almost a direct result that the *unit value* has been increased fairly regularly over recent months. It is with a great deal of pleasure that we notify you that our unit value for December of 1942 has been set at $1.50 per unit, which represents a very healthy increase over the unit value for December, 1941, which was at the all-time low of $1.10. We look forward to further increases in the unit value with considerable optimism.

The *Rural Health Program* has not worked out as well as we had hoped. Several factors have interfered with our extension of this enrollment, and our program at this point is only about twice the size of last year's, and therefore still pretty much of an experiment. We have encountered considerable opposition from officials of the State Farm Bureau, who have advised their local bureaus against coöperation with C.P.S. and the Farm Security Administration in developing groups in their counties. Needless to say, we expected some opposition, but are disappointed to find that it has had such a powerful effect. The Farm Security Administration has had administrative difficulties of its own in connection with

* Headquarters office of California Physicians' Service is located at 153 Kearny Street, San Francisco. Telephone EXbrook 0161. Los Angeles office address: 1151 South Broadway. Telephone PRospect 3114.

reductions in their personnel as a result of reduced appropriations, and through the drafting of a number of their key personnel for service in the armed forces. For these reasons, they have not been as effective as they would have been in normal times, and have been unable to offset the effects of the Farm Bureau opposition. We shall continue to press for extension of these plans in the rural communities, because we believe that the greatest needs and dangers exist in the rural communities.

You will remember that the Council approved our offering a special plan to the Joshua Hendy Iron Works, and to the Aluminum Company of America, in which C.P.S. would accept responsibility for both industrial and nonindustrial illnesses and injuries. We have proposed these plans to these employers, but they have not yet come to completion.

The most important new activity of C.P.S. has, of course, been the plans for *medical care for residents of War Housing Projects* throughout the state. This program is progressing very successfully, and is filling a real need in the communities where we are operating. At present, we have medical center plans in Marin City, in Vallejo, in Los Angeles and in San Diego, with approximately 40,000 persons enrolled thereunder. We are receiving excellent coöperation from the Housing Authorities, who have agreed to enroll the residents and make the collections of the dues with rent. We have also received the utmost in coöperation from the Procurement and Assignment Service, from the United States Public Health Service, the Red Cross and other interested agencies. We expect to extend this program to other communities in the near future, and the ultimate potential is in the neighborhood of 250,000 persons.

With respect to this program, we believe the Council should know that we have received, on behalf of the California medical profession, endless compliments from all interested sources. Even those groups formerly opposed to anything operated by the medical profession have had nothing but praise for this undertaking.

Financially, the program so far has been developed well within the income, and with a very decent return to the doctors for their services. We hope and believe that it will continue to be successful, and as greater volume is secured in the additional projects, this balance can be maintained. So far we have not had any insurmountable difficulties in securing the nurses and doctors to staff the medical centers. However, as we expand the problem will become more difficult.

It is our considered opinion that the prospects for the future are brighter than they have been at any time in the past. Unless something unforeseen develops within the next year, every indication is for a permanently successful C.P.S. organization.

Very sincerely,

A. E. Larsen, M. D.,
Executive Medical Director.

LOS ANGELES

Some Highlights in Its History

(Continued from Page 165)

Many problems confronted the new government. There was conflict between Spanish and American custom and law—land law especially.

During all of this period Los Angeles was a very small town, with unpaved streets and no means of communication other than the stagecoach and pony express rider. In 1860 the first telegraph line came to the city. In 1868 the first bank was opened. In 1869 San Pedro and the harbor-to-be, were connected to the city by rail. Then in 1876, the most important factor in the history of Los Angeles occurred—the first railway came to Los Angeles. In 1885 the Santa Fe followed the Southern Pacific.

It had taken Los Angeles ninety years to gain the 5,000 population it possessed in 1870. From this date, growth was much more rapid. The first railway had caused the population to double by 1880. During the next ten years the population jumped 350 per cent so that, by 1890, there were 50,000 persons in Los Angeles; many of whom had taken advantage of the railway rate wars which made it possible for immigrants to come from the Middlewest to Los Angeles for fares as low as one dollar! By 1900 the population had again doubled to more than 100,000. (Editor's Note.—The one dollar fare was offered on only one day.)

In 1885 California citrus fruit won over Florida fruit for the first time at the International Exposition at New Orleans. The local residents began extensive planting of fruit and the Chambers of Commerce began displaying the local agricultural products throughout the United States at fairs and expositions. Literature of all kinds, describing the climatic and tourist attractions, was mailed, and because of this constructive program, conditions improved.

With increased agricultural production, commerce came into evidence. Domestic trade had been carried on spasmodically for a considerable time, but it was not until 1899, when the first actual work began on a deep-water harbor, that the city undertook an extensive foreign trade program.

During 1899 and 1900 a boom in oil began and carried on to such an extent that today the production of crude oil and its refining is a leading industry. Los Angeles' second industry—motion pictures—got its start in 1910 when the first film company came to Hollywood—a foothill section which is now a part of the City of Los Angeles.

Additional information of statistical nature, appears below:

Area—City, 451.1 sq. miles; County, 4,071 sq. miles.
Assessed Valuation, fiscal year 1941-42.
L. A. City—
County valuation (Realty and Personal) .$1,185,823,889
L. A. County —
County valuation (Realty and Personal) .$2,324,139,634
State valuation (Public Utilities) 257,707,530
Total$2,581,847,164
Banks—Jan. 1, 1942—11 Banks with Branches.
Total Resources$1,709,600,100
Building Permits—
1941—Number.....40,245 Valuation.....$87,238,818
Churches—1,010, City; 1,833 (1940), County.
Hospitals—115; 34 hospitals with maternity cases, 26 without; 55 sanatoria; total beds, 8,350.
Elevation—Average 270 ft., City Hall official 318 ft.
Theaters—Motion Pictures, 264; Stage, 60; 24 Studios, 15 major producers; 112 active independents.

Schools

Public schools, City, 413; County, 806, including 611 elementary, 141 high, 49 evening high and 5 district junior colleges.

Libraries

Volumes in city library, 1,641,195; county, 568,707.

Streets

The city has 5,041 miles of streets, 2,068 paved, 1,107 improved but not paved, and 1,866 unimproved.

Telephone, Telegraph and Radio

Telephone stations, 504,726 city; 870,526 county. This is equivalent to about one telephone for every 3.3 men, women and children in the county; or one for almost every family, placing this section in this respect far ahead of all other similar areas in the world.

(Continued on Page 212)

ANNUAL COUNTY MEDICAL SOCIETY REPORTS

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties.

Calvert L. Emmons, Ontario, *Councilor.*

Imperial County Medical Society

The Imperial County Medical Society meets the second Tuesday of each month at the Barbara Worth Hotel in El Centro. The meetings are preceded by a dinner. There are no meetings held during the summer months of July, August and September.

There are at present twenty-one physicians in Imperial County, sixteen of which are members of the Medical Society. There are nine military members, four of which are in the Army and five in the Navy. Last year there were two military members and the Society had a membership of twenty-eight members. Four members have moved from the County to establish practices in more populated centers.

There is at present approximately one physician for each three thousand population not including military personnel or dependents.

HENRY FORCHER,
Secretary.

Orange County Medical Association

The Orange County Medical Association finished the year with eighty-eight members. Three of these live outside the county, which leaves us only eighty-five active practicing physicians. Our membership represents almost one hundred per cent of the doctors practicing in Orange County, since there are very few men who are not members. To the present time we have lost thirty-eight men into the service. This includes one in the United States Public Health Service and one in Veterans' Administration. This represents about one-third or thirty-three and one-third per cent of our men in the armed forces. Our loss is even greater than that figure would indicate since perhaps one-third of those remaining are men, who, because of age or disabilities, are not carrying on a very active practice.

The city of Orange has been particularly hard hit by military losses. Four men have entered the service leaving but one man, Dr. Wallace, a man who has practiced medicine fifty years, but who is still quite active. One of the losses has been replaced with an eastern man, but it still leaves a community of about 9,000 with but two doctors.

One member, Dr. W. T. Harris, was lost by death and two members moved out of the county to enter other fields. We have, however, gained four new members, although one of these is now with the armed forces.

The Society's secretary, Dr. M. K. Tedstrom, was called into the air forces in May and is now a major and stationed at Mather Field. Dr. L. F. Whittaker was appointed to fill his unexpired term.

Ten meetings were held during the year, there being no meetings during July and August. All meetings, with the exception of one, were dinner meetings, held at the Rossmore Cafe, in Santa Ana. An outstanding program for the year was one put on by medical personnel from the Santa Ana Army Air Base. Many of our other programs have dealt with problems of civilian defense, etc.

The editor of our Bulletin, Dr. Thomas Rhone, was called into the air forces in the early fall, and his position was filled by Dr. Mary C. Block, who has carried on admirably with the work.

The Woman's Auxiliary, under the leadership of Mrs. J. W. Truxaw, waged a gallant fight for the Basic Science Law and it is reported to have carried in Orange County.

The Society this year was the recipient of a beautiful plaque containing the names of members in service, presented by the out-going president of the year, Dr. C. Glenn Curtis. We were also presented a large silk service flag by the local O.C.D. officers.

The Orange County Medical Association continues to enjoy almost one hundred per cent membership in the Public Health League. Public Health League dues are collected each year with the membership dues.

The Association begins the new year under the leadership of enthusiastic new officers, and while our attendance at medical meetings will be much smaller than it has been during the years past, and while outside speakers will be more difficult to obtain because of doctor shortage and gasoline and tire rationing, we are looking forward to a successful year in 1943.

L. F. WHITTAKER,
Secretary.

Riverside County Medical Society

The Riverside County Medical Association has about fifty-five active members, three retired members, two honorary members, and one associate member. Twenty-one are in military service.

The Association meets monthly with the exception of July, August, and September, at the Riverside Community Hospital. The programs usually feature a guest speaker presenting some subject in the scientific field, followed by discussion from the floor. A mimeographed bulletin is sent out the week before the meeting and contains notes on business transacted by the Council and announces the program for the following week.

Physicians from the Army and Navy Hospitals near Riverside, are invited and urged to attend our meetings, and many do so.

War conditions have brought a considerable change in the medical situation in Riverside county, a greatly increased population, with many of our doctors in service, has made a tremendous demand on the remaining doctors. Some of our outlying areas have no doctors at present.

Nineteen forty-three is an important date to the Riverside County Association as it marks the 50th anniversary of our organization. The May meeting will be a Golden Anniversary, honoring some of the older members.

W. K. TEMPLETON,
Secretary.

San Bernardino County Medical Society

Of the one hundred sixty-three members in the San Bernardino County Medical Society, thirty-eight have entered the armed forces. These latter are of course exempted from paying dues.

Regular meetings are held the first Tuesday of each month, October through June, there being no meetings during July, August and September. Notices of meetings are sent regularly to the medical personnel of the army and defense camps. In general, the meetings are held at the County Hospital, but the College of Medical Evangelists at Loma Linda entertain the Society for one meeting, putting on the program. We hold one political meeting during the year, at which County and State officials are in attendance. These meetings are always well attended.

Two postgraduate meetings were held during the year, one on "Pediatric Problems" and the other on "The Medical Treatment of Gas Injuries" and the speaker was from the Division of Chemical Warfare, U.S.A.

ARTHUR E. VARNEN,
Secretary.

San Diego County Medical Society

During the calendar year of 1942, the San Diego County Medical Society has held the usual ten monthly meetings, all well attended with very good programs. The food situation has given us some difficulty with the result that we have had to forego the usual dinner prior to the scientific session. An effort is being made to combine the County Society meetings with the several staff sessions so as to conserve energy, time, rubber and gas. In a smaller community with overlapping memberships this combination for the duration seems to be in order.

Out of a total membership of 340, 103 are in the military service. Added to this we have twenty-two applicants. This covers the entire county and by readjusting our schedules and working a little harder, the local profession is handling the medical needs of the communities in a fairly satisfactory manner.

The most important problem the local profession has had to face is the matter of the care of defense workers in the large government projects here, especially the C.P.S. Linda Vista undertaking. This is being watched with varying reactions by our members. Frankly, we are not unanimous in our opinions about it. Problems naturally have arisen and we are endeavoring to solve them for the best interests of both the profession and the patients who are in no way indigent. More problems will arise and we will continue to do our best for the good of all concerned. Of course underlying it all is the basic question that faces the entire medical profession through-

out the country, i.e., bureaucratic control and the destruction of the American way of living.

The Emergency Medical Service, under the leadership of Dr. T. E. Toomey, now in the Navy, has been working all year to establish ways and means for caring for casualties in case of an "incident." Dr. Toomey and his coworkers have labored incessantly, at times all day and all night at a stretch. His going has, of course, made some readjustment necessary. However, Rear Admiral Blakely. U.S.N. retired, has been appointed as Chief of the E.M.S. with Dr. Pinco as his full-time assistant. Under their leadership the work is being carried along, and we feel that we are ready for duty, as far as we can be, without having had previous actual experience.

W. H. Geistweit, Jr.,
Secretary.

SECOND DISTRICT

Los Angeles County.
Donald Cass, Los Angeles, *Councilor.*

Los Angeles County Medical Association

The activities of the Los Angeles County Medical Association during the past year could no better be expressed than to paraphrase the report of the aviator who "Sighted sub, sank same." The usual routine work at our central office has been to a considerable degree displaced by requirements of the Procurement and Assignment Service, the local city and county civilian defense needs, and the considerable amount of detail required in connection with clearing applicants for membership and certifying our members to the different branches of military service.

Our Council has been aware of the many problems consequent upon gasoline rationing as they apply to a practicing physician. To help in adjusting differences that have arisen between rationing boards and physician members, a special committee has been appointed. This committee has been active and aggressive in its study and recommendations. It has conferred with a similar committee of the Los Angeles County Dental Association on problems common to the two professions in this community. Meetings have been held with representatives of the Office of Price Administration, as the result of which regulations were issued providing special concessions to patients suffering with chronic diseases such as diabetes, anemia, tuberculosis, and other nutritional disturbances, to the end that they might obtain needed scarce foods.

The Library of the Association has been unusually active in meeting the requirements of our members in the armed forces for journals and books to be sent by parcel post. Also, it has acted as a clearing house to collect and distribute sets of journals and recent text books to medical units located in this territory in order that those units might possess at least a skeleton library of their own.

The Association is aware of its responsibility not only for the most efficient administration possible of health matters in this county during the war, but also of the acute need for an intelligent, constructive plan to help its members return to civilian practice after the war is over. In a time when the panacea vendors are bursting forth like crocuses in spring with all kinds of nostrums for our economic salvation, organized medicine must stand fast and insist that just a modicum of common sense and realism be one of the component parts of the potion when it is finally brewed.

L. A. Alesen,
Secretary.

THIRD DISTRICT

Inyo-Mono Counties, Kern, San Luis Obispo, Santa Barbara and Ventura.
Harry E. Henderson, Santa Barbara, *Councilor.*

Inyo-Mono County Medical Society

Since our last report the small Inyo-Mono County Medical Society has sent three men into the service. Our roll call now gives us a total of seven members, five of whom are in active practice. As in previous years the dentists of the county attended our meetings. This association brings our combined membership to ten. We, of the medical profession, find that this association is a very real and valuable asset.

This last year our members decided to discontinue our customary three-month recess. The policy was established in the interest of medical problems that arise in spite of recesses in these days of war. Unlike other societies, our usual yearly recess is held during December, January and February. During those months snow frequently makes travel difficult. Throughout the year we have held our meetings in the larger towns of Inyo County, namely, Bishop, Independence and Lone Pine. In this way we have attempted to minimize travel for any one group.

As in past years, representatives from the Kern County professional men again found time to come to Inyo. Our Society held one meeting at the Manzanar Japanese Relocation Center. A tour of the hospital at the Center could not help but make us pray that the Americans who are unfortunate enough to be held by the Japanese may be getting care just half as considerate.

With no physician in Mono County and a reduction in Inyo County's medical coverage, we find that our problems are increasing, but we always like to say: "Do not judge our activity by our size."

Joseph W. Telford,
Secretary.

Kern County Medical Society

Kern County Medical Society has a membership of seventy-two with eighteen members in military service as of December 31, 1942. Meetings of the Society are held on the third Thursday evening of each month throughout the year at the Padre Hotel in Bakersfield.

Dr. William H. Moore served as Program Chairman during 1942, and excellent scientific programs were presented. An outstanding program was given by Dr. Arthur Smith, of Los Angeles, on Plastic Surgery, to which members of the Dental Association were invited.

In March, 1942, a Postgraduate Conference was held in Bakersfield with eighty-eight physicians registered from the counties of Kern, Santa Barbara, Ventura, San Luis Obispo, Kings, Tulare and Mono-Inyo. Doctors R. A. Ogden, James Stanton, Keith McKee and L. A. Packard served on the Committee. This was one of the best conferences held since the inauguration of these conferences by the Third District. In May, 1942, four members of the Society presented papers at a meeting of Mono-Inyo County Medical Society and the trip was much enjoyed.

A strong campaign of publicity was carried out in favor of the Basic Science Law. The Society appreciated the efforts of the Committee with Dr. Lucille B. May as Chairman of the Woman's Auxiliary, and of Mrs. Keith McKee who gave a radio talk in favor of the ill-fated proposition.

Kern County has two large air fields, Minter Field and Gardner Field. Much consideration has been given the problem of adjustment of fees, in coöperation with the Red Cross, for medical care for families of noncommissioned personnel at these fields. Throughout the year a special effort was made to invite the Medical Officers at the fields to attend the meetings of the Society and their participation has been much enjoyed. In turn, the members appreciated the opportunity to tour the hospital at Minter Field in December, 1942.

The court action of Dr. Joe Smith vs. Kern County Medical Society was decided by the Supreme Court in favor of the Society. In May, 1942, the Society approved the attempt of Dr. J. M. Kirby, Superintendent of the Kern General Hospital, to form a staff and members of the Society have been asked to coöperate. Dr. William H. Moore was elected president of the Kern General Hospital Staff and at the present time many members are serving on the visiting staff. This service is a distinct contribution to the war effort as the hospital is now operating with approximately one-third of its usual resident staff. Kern County has responded to the call for military service and in Bakersfield approximately one-half of the physicians are in the Army or Navy. The remaining physicians are aiding in Civilian Defense activities under the capable leadership of Dr. C. I. Mead. Doctors William Moore, Seymour Strongin, L. A. Packard, Lucille B. May and Lloyd Fox have served on the Procurement and Assignment Committee. New defense plants soon to be opened in Kern County will tax the medical personnel available to the civilian population.

Dr. J. Headen Inman served as president of the Society. Other officers during 1942 were James Stanton, vice-president, and Sophie M. Loven, secretary.

Serving on the Board of Directors were F. J. Gundry, C. S. Compton, C. I. Mead, R. A. Ogden, William H. Moore, H. W. Lange, and Lucille B. May. Delegates were

Doctors C. S. Compton and F. J. Gundry, with Doctors Lucille B. May and Seymour Strongin as alternates.

The Society regrets the change of residence of Dr. L. A. Packard to McAlester, Oklahoma. Dr. Packard served the Society untiringly for many years and as Councilor kept the Society in close touch with the California Medical Association.

SOPHIE M. LOVEN,
Secretary.

San Luis Obispo County Medical Society

The following is a report of the activities of the San Luis Obispo County Medical Society for 1942:

Meetings are held the third Wednesday of each month; eleven meetings being held during 1942. No meeting was held in July.

The membership in 1942 was twenty-nine, including the following who are now serving in the armed forces: Elmer M. Bingham, U. S. Navy; Newell Nay, U. S. Navy; Willis D. Butler, U. S. Army; Charles R. Kennedy, U. S. Army, and Albert Shershow, U. S. Army. Four new members were elected in 1942.

Because of travel difficulties, most of our meeting programs have been participated in by our own members, or we have obtained motion pictures from pharmaceutical houses.

During the past year the Society members have played an active part on the Staff of the County General Hospital, during which time a wing has been opened, devoted exclusively to communicable diseases.

Due to the large influx of population, particularly in San Luis Obispo and Paso Robles, the medical problems have increased tremendously, making each individual physician's load greatly increased, but so far the medical profession has been able to cope with the situation and render excellent service to the communities. The number of births in the county in 1942 doubled the births of 1940, giving some indication of our population increase. The total number of physicians has remained about the same, there being several replacements for those having entered military service. With any further depletion in the number of physicians in the county, there would most likely be a serious lack of proper medical attention; so far this has not been apparent.

We feel that during the past year the Society has been very active and vitally interested in the medical problems created by the war, and all the members have been anxious to serve in whatever capacity they can to get over a very difficult period with as little disruption as possible to the public and to the medical profession.

HARRISON EILERS,
Secretary.

Santa Barbara County Medical Society

The Santa Barbara County Medical Society has an active membership of 118. Regular meetings are held on the second Monday evening of each month, except July and August, in the Bissell Auditorium of the Santa Barbara Cottage Hospital.

The January meeting is always a dinner meeting and was held in the Gold Room of El Paseo Restaurant. The entertainment consisted of singing and dancing by the El Paseo entertainers and sleight of hand by Maldo the Magician.

During 1942, twenty-five members of the Society entered the Army Medical Corps and nine members entered the Navy Medical Department, which with the members who had entered the armed services during 1941, makes a total of thirty-seven members in active service with the armed forces.

Guest speakers during 1942 were as follows:

February—Mr. Billy Burke, Hollywood, California, "Colored Motion Pictures of Surgical Anatomy."

March—Dr. Edwin F. Patton, Los Angeles, "Malpractice Prophylaxis."

May—Dr. Edw. L. Sugar and Lieut. M. Gurdin, U.S.N.R., "Plastic Surgery of Burns."

June—Lieut. Col. Wm. P. Corr, Hoff General Hospital, "Acute Toxic Hepatitis."

November—Dr. Montague S. Woolf, San Francisco, "Medical and Surgical Aspects of Chronic Ulcerative Colitis."

December—Dr. Frank S. Dolley, Los Angeles, "Treatment of Chest Trauma."

This Society during 1942 was greatly saddened by the death of its incumbent President, Dr. Lawrence F. Eder, whose loss is greatly felt by his colleagues and the community in which he lived and practiced.

In June of this year, the new Santa Barbara County Medical Society Library, which is situated in the Cottage Hospital, was formally opened. This was made possible by the generous donation of Mrs. Emma Wood of Carpinteria and is filling a long felt need.

This Society publishes a monthly mimeographed bulletin by means of which information of value to the members is disseminated.

It can be said with considerable pride that all eligible members of this Society have applied for commissions in the armed forces. Those remaining do so only because of physical disability with official War or Navy Department rejections if under 45, and if over because of essentiality to the community needs.

ALFRED B. WILCOX,
Secretary.

Ventura County Medical Society

Ventura County Medical Society has a total membership of fifty-two members. There are eighteen members in active military service. The head of the local Procurement and Assignment Board advises this is 100 per cent of those eligible and physically fit for military duty.

Members in military service are exempt from dues.

Meetings are held monthly at the Country Club in Saticoy where we enjoy fine meals prior to each business and scientific meeting. Many excellent motion pictures and lectures have made up our programs.

The Woman's Auxiliary of the Ventura County Medical Society continues to carry on active work.

Our County Hospital cares efficiently for all indigent persons who wish care.

M. M. RAINES,
Secretary.

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties.
Axcel E. Anderson, Fresno, *Councilor.*

Fresno County Medical Society

The Fresno County Medical Society held ten regular monthly meetings during the year 1942, observing the usual vacation months of July and August. The meetings are held in the University-Sequoia Club, and we usually have a guest speaker from one of the medical schools of either San Francisco or Los Angeles.

We have 109 active members in our Society, with forty-two of our members now in military service. However it is felt that the medical needs of the communities in Fresno County are adequately covered, since Fresno has very little industrial defense work.

J. A. THORMANN,
Secretary.

Kings County Medical Society

The Kings County Medical Society held ten meetings during the past year. There were no meetings in the months of June and July. Two new members were added to the active membership of twenty-one, and seven members entered the various branches of military service during the year.

ARTHUR ZEISMER,
Secretary.

Merced County Medical Society

The year 1942 ended with a membership in the Merced County Medical Society of eighteen. With active members totaling thirty-nine the previous year, it is quite evident that the Army, Navy, and Air Corps have greatly depleted our list. Nineteen of our members are now serving in the Armed Forces. Two new members were added and four were transferred.

However, in spite of this reduction, regular meetings were held (except during the summer months) on the third Tuesday of each month, at the Hotel Tioga in Merced.

During the various sessions of the Society many interesting and educational topics were discussed by guest speakers, among whom were: Dr. Cabel of Fresno, who spoke on "Common Duct Obstructions," Dr. Anderson, also of Fresno, discussed matters relating to the organization

in general. Dr. Ginsberg of Fresno, delivered a most enlightening talk on Sister Kenny's treatment of Poliomyelitis. Of special interest in October meeting were talks on the "Physical and Physiological Considerations of Flying," by Captains Wall and Dorsey and Lieutenants Yoder and Quinn from the Merced Air Base.

In June, a time of fellowship and fun was enjoyed by the members at the annual picnic, held at the Merced Golf Club.

A committee of three has been serving every Thursday evening at the General Hospital to examine draftees.

Committees have also been appointed by the President on: Medical Defense, Postgraduate Study, Needy Physician's Plight, Credentials and Ethics, and also two members to assist the Chief of Staff at the County Hospital.

C. C. Fitz Gibbon,
Secretary.

San Joaquin County Medical Society

Meetings were held monthly in the club rooms at Stockton, except in June, July and August of last year. Monthly meetings were preceded by dinner sessions. The program committee, of which Dr. Elmer Smith is the chairman, carried on splendidly in spite of the difficulties in obtaining out-of-town speakers. Among the guest speakers who visited us were Drs. Harold Fletcher, Carlton Mathiewson, Edward N. Ewer, Leroy C. Abbott, John B. de C. M. Saunders, H. Glenn Bell, T. L. Althausen, William J. Kerr, Robert A. Peers, and the medical officers of Stockton Field, Col. John L. Gallagher, Major J. E. Rich, Capt. L. Hedde, and Capt. T. R. Calhoun.

Of our group of 117 active members, 38 members are now in the military services. They are Drs. E. A. Anderson, W. T. Auld, N. P. Barbour, E. L. Blackmun, H. W. L. Collis, Robert Dyar, J. O. Eccleston, M. Edelstein, Edward Faulkner, P. B. Gallegos, L. S. Gale, M. M. Green, R. A. Greenman, E. P. Halley, D. C. Harrington, N. P. Johnson, P. V. Lamb, S. W. Leiske, J. E. Longley, John C. Lynch, R. D. Maurer, F. A. McGuire, P. H. McHugh, V. D. O'Connor, B. J. Powell, Jr., H. F. Quinn, G. C. Richardson, H. C. Rixford, J. L. Rosasco, V. R. Ross, Julius Schreiber, C. V. Thompson, L. F. Tretheway, A. M. Tunnell, F. G. Vieira, G. K. Wever, and H. C. Petersen, Jr.

The Society assisted in the campaign for the Basic Science Act by placing political advertisements in the local papers. Stockton has increased in population from 60,000 to about 90,000 due to the influx of the shipbuilding and other war industries. The members of the Society are coöperating to the fullest extent in providing adequate medical care for the communities. They have also given their services in aiding the selective service boards and the civilian defense organizations.

Dora Ames Lee,
Secretary.

Stanislaus County Medical Society

Nine regular meetings of the Stanislaus County Medical Society were held during the year 1942.

Vacation months are July, August and September. Membership in the Society is fifty-two. Sixteen members are in the armed services, leaving thirty-six doctors in practice, covering a population of about eighty thousand. One member is inactive and one member, Dr. Vincent Vielhaber of Patterson, recently expired (1943).

There is one new doctor in Modesto above military age who will probably become a member of the Society.

Apparently there are no areas lacking in medical services, doctors in small outlying towns having been considered essential to their ommunities.

H. R. Gant,
Secretary.

Tulare County Medical Society

The Tulare County Medical Society has held eight meetings during 1942. Meetings are always held in Visalia and are well attended. Meetings are not held during the summer months of June, July, August and September.

Because of wartime conditions we are experiencing difficulty in obtaining speakers for our meetings so that some of our meetings have been purely of a local and business nature.

There is an active membership of 35 members with 16 members in the armed services. Two other men in the armed services are not included in the membership because of having joined the colors before their applications could be acted upon. There is only one eligible nonmember in the county.

No deaths have occurred during 1942.

Frank R. Guido,
Secretary.

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties.

R. Stanley Kneeshaw, San Jose, *Councilor.*

Monterey County Medical Society

There are sixty-nine names on the roster of the Monterey County Medical Society. Twenty-one of this number are in the armed forces of our country, and one is overseas with a government-sponsored airplane plant. A further breakdown of these twenty-one members shows fourteen in the army, and seven in the navy. The Society is at present represented in the four corners of the world. Two Japanese members of the Society are no longer active.

Meetings are held on the first Thursday of each month, with the exception of the summer months, July and August. During 1942, the Society was fortunate in having several interesting programs with distinguished speakers. At the January meeting, Dr. Sidney Sinclair spoke on "Immunization in Children." In February, Major E. E. Ludmell of Fort Ord, spoke on "Duties of a Medical Officer." Dr. Robert Scarborough had as his subject for the March meeting, "Rectal Diseases." In April, Dr. Jesse Carr presented a paper and film on the topic, "Breast Tumors." A group from the medical staff at Fort Ord Hospital, gave a symposium on "War Injuries." The meetings were alternated between the Del Monte Hotel and the Santa Lucia Inn, at Salinas. This year the Del Monte Hotel has been taken over by the navy, and meetings are being held at the Del Monte Lodge, at Pebble Beach.

The Woman's Auxiliary of the County Society has had an active year. During the State meeting at the Del Monte Hotel in May, they ably arranged programs, registrations and entertainment for guests. Various functions were held to raise funds for their activities. The Auxiliary has always been a ready and willing coworker in the problems of the Society.

Monterey County has been hard hit by the enlistments of one-third of its young, active doctors in the military services, but there has been no suffering or lack of medical care among the civilian population. There has been inconvenience perhaps, but the remaining doctors are working overtime, like elsewhere, to keep up the standards of private practice. Many of our retired members have returned to active practice to do what they can to help. Probably the greatest problem confronting this area is the shortage of nurses. Luxury nursing is over for the duration.

The County Public Health Department maintains clinics in Monterey, King City, and in Salinas at the County Hospital. They are understaffed, but with the aid of consulting and attending members, maintain an active and efficient service. The increased ability of the former indigent to pay private fees, has reduced the load on the county clinics.

Monterey County is carrying one.

S. Condit Glasgow,
Secretary.

San Benito County Medical Society

The following is the report of the San Benito County Medical Society requested by you in your letter of February 24, 1943:

Membership: Number of active members, six; decrease of one, and one new member since last year. Number of members in military service, two in United States Army and one in Canadian Army.

There are eight licensed physicians who are in practice in San Benito County.

The meetings are held from time to time in Hollister, upon call of the President.

The Woman's Auxiliary to the San Benito County Medical Society, meets with that of the Monterey Society.

L. E. Smith,
Secretary.

San Mateo County Medical Society

The San Mateo County Medical Society holds meetings each month, with the exception of June, July and August,

the vacation period. These meetings are held in San Mateo and are planned by the Secretary and the Program Committee.

The present membership is 100 per cent of ellgible physicians. During the past year three new members and one transfer member were accepted into the Society. Twenty-two members have entered the service of the United States Government.

The Society has a Woman's Auxiliary which ordinarily meets on the same night as our Society. Two or three times a year, the Society and Auxiliary hold joint meetings.

LOGAN GRAY,
Secretary.

Santa Clara County Medical Society

Santa Clara County Medical Society, like all other medical societies, has been more or less disrupted during the past year because of so many members entering the armed services. Our membership on January 1, 1942, was 208, and twenty new members were elected during the year. Seventy of our members are now in active military service.

Our regular monthly meetings, except during July and August, our vacation time, have been held, and the attendance has been very satisfactory.

The outstanding scientific activity of the year was the annual San Jose Hospital Lectures Course, which was initiated sixteen years ago. This year we were favored by having Dr. William Carpenter MacCarty of the Mayo Clinic as our guest for a week. This was his second visit with us, he having initiated our course in 1926. While this course of lectures was under the auspices of the San Jose Hospital, it was open to all members of the Society and guests, and his five lectures were very well attended. We believe there is nothing more stimulating than to bring to our midst some outstanding teacher who spends a week with us. Several dinner parties were given in honor of Dr. and Mrs. MacCarty preceding his lectures, and such meetings are very conducive to good fellowship among the members of the profession.

While we have lost a great many members to the armed forces, and the stay-at-homes have had to shoulder more work, and even though we have a reasonable amount of defense industry in the county, we are not yet sufficiently short of physicians to even consider the lowering of standards and requirements of the Board of Medical Examiners to induce alien physicians to come to our county. We feel that even if those of us at home have to carry a considerable additional amount of work during the war years, we owe a solemn obligation to our members who have gone into service to preserve as nearly as possible all the opportunities for them upon their return.

JOHN HUNT SHEPHARD,
Secretary.

Santa Cruz County Medical Society

Under the able leadership of President Mahlon D. McPherson of Santa Cruz, the Santa Cruz County Medical Society had a very successful year in 1942.

Meetings were held during the months of January, February, March, April, May and November, at the Club Rio del Mar, Aptos. This is a very convenient meeting place inasmuch as it is situated approximately midway between Watsonville and Santa Cruz, the two populous centers of the county. The October meeting was held at the residence of President McPherson at which time our host provided a venison dinner for the members. The December meeting was held at the new addition to the Santa Cruz County Hospital and the meeting included a tour of inspection through the new building. As has been our custom for many years no meetings were held during the summer months of June, July and August.

The programs for the meetings are arranged by the President in collaboration with the program committee. An attempt is made to vary the subject matter so as to appeal to the particular interests of all members during the year. The following appeared during 1942: Doctors L. F. Hawkinsen (Endocrinology), Ernest Falconer (Leukemia), Earl Miller (Roentgenology), and Colonel Robert C. Murphy (Military Medicine). At several of the meetings scientific motion picture films were presented. At one meeting the staff of the county hospital presented the scientific program.

As of January 1, 1943, we had 43 active members including 10 members absent in the military service.

SAMUEL B. RANDALL,
Secretary.

SIXTH DISTRICT

San Francisco County.

John W. Cline, San Francisco, *Councilor.*

San Francisco County Medical Society

A general survey of the work done by the San Francisco County Medical Society during the year 1942, was published in CALIFORNIA AND WESTERN MEDICINE, issue of January, 1943, on page 39. (Annual Report of the President, Dr. John W. Cline.)

As an appendix to this comprehensive report, the following items may be of interest:

1. *Scientific Programs.* The scientific sessions were telescoped at the end of the year into one general meeting each month, partly to conserve rubber and partly to save the time of busy physicians.

2. The year 1943 will see our Society ninety years of age, its birthday having been November 17, 1853. It is the eleventh largest medical society in the United States and had a membership of almost 1,200 at the close of the year. Of these some 400 were on active military duty.

3. *Blue Cross Plans.* Group hospitalization is a recognized method of budgeting the cost of hospital care. In some communities the Blue Cross organizations furnish straight hospital services through their contracts, but in others they attempt to furnish not only hospitalization but also diagnostic medical services (pathology and radiology). This is one of several reasons why no Blue Cross plan or group hospitalization organization has ever been approved by the American Medical Association! It is the considered recommendation of the organized medical profession that Blue Cross plans should furnish only hospital services, and should not attempt to furnish any part of medical services (surgery or radiology or any other) as a part of hospital care. Our local Blue Cross plan furnishes indemnification for diagnostic medical services, and in some instances follows the indemnification through to the letter. In others, it pays a corporation for a medical service and thereby evades both the letter and the spirit of the original agreement with the medical profession of the Bay district. These facts have been brought to the attention of the Board of Directors of Hospital Service of California and we are happy to state that some of those directors have given us assurance that in future they will attempt to see that medical men are paid for medical services.

4. *Tuberculosis Surveys.* Further conferences were held with officials of the Public Health Department and the San Francisco Tuberculosis Association relative to these surveys. It is to be regretted that for various reasons the Board of Education has not yet proceeded with its survey of school teachers. Of interest is the fact that in Sacramento such a survey is being completed along lines identical with those proposed by your radiological members two years ago. The great importance of considered deliberation before proceeding with surveys is exemplified in recent actions regarding industrial chest examinations. The San Francisco Tuberculosis Association is to be congratulated on attempting to educate industrialists on the need for such surveys. It is to be hoped that every reasonable means will be used to employ existing medical facilities for this important nonindigent work. The highest incidence of tuberculosis is known to prevail among low-income groups, and it is especially desirable that members of such groups in a position to spread the disease readily (domestics, food handlers, janitors, etc.) should be examined.

5. *Woman's Auxiliary.* The Woman's Auxiliary has again done yeoman work during the year. It has staffed the County Society's Blood Bank Canteen and acted as its Motor Corps; it worked strenuously for the adoption of the Basic Science Initiative; it staffed and ran the Civic Center Hospitality House on County Medical Society Day, and performed numerous other volunteer tasks quietly and efficiently. Notable amongst the latter was the work for the County Society Procurement and Assignment Service. To Mrs. R. W. Burlingame and all the other doctors' wives we extend sincere thanks for a difficult job well done.

6. *Dues.* The Board of Directors set the dues for 1943 at $40.00, this being a reduction of $1.00 in the Society portion of the dues and an increase of $5.00 of the State Association assessment. The net result, therefore, is that the 1943 dues are $40.00. The departing secretary-treasurer observed that, "Even if you are on military leave, there is no rule against paying your dues should circumstances so permit. A virile organization deserves and requires the help of every member in a position to render such."

CHESTER L. COOLEY,
Secretary.

SEVENTH DISTRICT

Alameda and Contra Costa Counties.
Frank R. Makinson, Oakland, *Councilor.*

Alameda County Medical Association

The year just passed has seen the Alameda County Medical Association functioning in its usual capacity with regular monthly meetings on the third Monday of each month except for the vacation period of July and August.

The scientific work of the organization has been largely performed by its own members with an occasional stimulating address by prominent guest speakers. The usual healthy growth of the organization has continued unabated in spite of war conditions. Fifty-two members were added to our roll during the year while sixteen members were dropped from the roll. Over two hundred of our members are serving in the armed forces of the United States, and daily others are being added to this list.

GERTRUDE MOORE,
Secretary.

Contra Costa County Medical Society

The following is the report of the Contra Costa County Medical Society for the year 1942, for the "Pre-Convention Bulletin."

At this time the membership totals sixty-five, three of whom are honorary members. The following members have joined the armed forces:

U. S. Army: Drs. Gaines L. Coates, H. B. Flanders, John J. Fitzgerald, and Paul F. Winn.

U. S. Navy: Dr. C. E. Dietderich.

Ten meetings were held during the past year, each of which consisted of a business session and a scientific program. The annual Christmas party was dispensed with this year. The scientific programs have consisted of interesting discussions by guest speakers, clinico-pathological conferences and surgical motion picture films.

J. M. BOOMER,
Secretary.

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Placer-Nevada-Sierra, Plumas, Sacramento, Shasta, Sutter, Tehama, Yolo, and Yuba Counties.
Frank A. MacDonald, Sacramento, *Councilor.*

Butte-Glenn Medical Society

Following is the report you requested in your letter of February 24th.

The Butte-Glenn Medical Society, during the past year, held eight meetings. The attendance was varied, 25 to 35 members being present.

Seven of our members are in military service. Two others who moved to different localities have also entered the service.

Our Society endeavors to meet on the 2nd Thursday of each month, with the exception of June, July, and August.

Ordinarily we attempt to have outside speakers but occasionally the local men take over the program. The men here participate actively in all worthwhile community and health projects and programs. The mayor of our city is E. L. Meyers, M. D., a practicing physician.

There are four others in our Society who will, possibly, be eligible for military service.

We have found the Woman's Auxiliary to be a very useful and a very patent factor in many of the projects we have to consider.

J. O. CHIAPELLA,
Secretary.

Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc County Medical Society has had a rather difficult year due to the death of our president, Dr. G. R. Fortson of Susanville, and due to the increased difficulties of travel and the wide distances separating our members.

A meeting was held in June, 1942, in Alturas in conjunction with doctors of Lake View, Oregon.

We have six members in military service and have acquired two new members by transfer from other County Medical Societies. There will be six eligible new members in the area as soon as they have been here the required length of time.

Establishment of the Sierra Ordnance Depot at Herlong, California, in Lassen County, has created an increase in population for this area, with a local inadequacy of medical care and hospital facilities which is being gradually worked out.

On January 30, 1943, at a meeting held in Susanville, Dr. Fred J. Davis, Jr., was elected president and Dr. J. W. Crever, Jr., was reëlected secretary for the year 1943.

J. W. CREVER, JR.,
Secretary.

Placer-Nevada-Sierra County Medical Society

The Placer-Nevada-Sierra County Medical Society, at the end of 1942, had a membership of forty-three. During the year we acquired three new members and we lost one member, Alfred H. Tickell, M. D., by death, and one member by transfer.

Because of the necessity to conserve rubber, it was decided to call only such meetings of the Society as were absolutely necessary. It was also decided not to ask speakers to come long distances except for very special reasons. As a result we had only four meetings during the year, as follows:

1. Dinner meeting of April 18, 1942, at which eighteen members were present. The visiting speaker was Mr. W. F. Higby, Executive Secretary of the California Tuberculosis Association, who discussed the coming tuberculosis case-finding drive among adults.

2. Dinner meeting at Sather's Grill, September 19, 1942. There were present ten members and seven visitors. This was a joint meeting of doctors and dentists in honor of Senator Seawell and Assemblyman Thurman. Mr. Doulton Burner, of the Retailers' Credit Association, of Roseville, discussed governmental regulations regarding open accounts and extension of credit.

3. Dinner meeting at the Freeman Hotel, on October 21, 1942, in honor of Dr. Dwight Wilbur, at which there were nine members present and two visitors, Dr. Dwight Wilbur and Captain Robert Stewart Peers. Following the meeting, Dr. Wilbur addressed a forum at the Junior College, the subject of his address being "Is Nutrition Important for Wartime Health and Efficiency?"

4. Annual meeting of November 14, 1942. At this meeting the following officers were elected to serve for 1943:

President: Lucas W. Empey, M. D., Roseville: Vice-President: George A. Foster, M. D., Grass Valley: Secretary-Treasurer: Robert A. Peers, M. D., Colfax: Delegate: William M. Miller, M. D., Auburn; Alternate: Max Dunievitz, M. D., Auburn.

A Special Committee, consisting of C. E. Lewis, M. D., Robert H. Eveleth, M. D., and Robert A. Peers, M. D., was appointed for the purpose of drawing up a new Constitution and By-Laws. With the assistance of Mr. Hartley Peart this has been accomplished and we hope in 1943 to have the new Constitution and By-Laws adopted. Our Procurement and Assignment Committee, which has consisted of Robert A. Peers, M. D., Chairman, William M. Miller, M. D., and Oscar F. Lang, M. D., reports that there are ten members of our County Society who are with the armed services. In spite of this, there is no part of our County Society district which is not well supplied with medical services.

ROBERT A. PEERS,
Secretary.

Sacramento Society for Medical Improvement*

The Sacramento Society for Medical Improvement meets on the third Tuesday of each month in the auditorium of the Nurses' Home at Mercy Hospital, 40th and Eve Streets, at 8:30 p.m. No meetings are held during the vacation months of July and August. Programs are arranged by a committee and the December meeting is devoted to Society business and the election of officers for the ensuing year. General meetings of the Society for the past year have included the following:

January 20th—A Symposium on the "Diagnosis and Treatment of Obstetrical Difficulties," by Doctors Laura Levinson, Eleanor Rodgerson, Hans Schiuter, and Andrew M. Henderson, Jr.

February 17th—Dr. E. Hale discussed "Sex Hormones."

March 17th—The seventy-fourth Annual Banquet was given at the Sutter Club.

April 21st—Dr. Chauncey D. Leake, Professor of Pharmacology at the University of California spoke on "War Gases."

May 19th—Lieutenant Commander Pendleton, Mare Island Navy Yard gave an illustrated lecture on "Treatment of Burns."

* This is the original name of this pioneer county medical society.—Ed.

June 16th—"War Surgery" was discussed by Doctor John Homer Woolsey.

September 15th—Captain Arthur Kaslow, Mather Field, spoke on the "Duties of a Flight Surgeon."

October 20th—"Peripheral Vascular Diseases" was the subject presented by Doctor William John Kerr, Professor of Medicine, University of California.

November 17th—Doctor Robert A. Peers, Colfax, spoke on "Tuberculosis," showing many x-ray slides.

Active members of the Society number 127. Those in military service now include 44; 13 new members were admitted. Death took 4 associates during the year: Dr. Frank B. Sutliffe, Dr. Frank McCullough, Dr. Fred F. Gundrum, and on December 16th, Dr. Joseph Dillon, Jr., was killed while on active duty in the mid-Pacific. Dr. Duncan McLean, after fifty-one years of service, retired.

No bulletin is published by the Society, the meeting programs being announced on printed notices which are sent to all local physicians whether or not they are members of the Society. Regular notices of the meetings are also sent to the physicians in military service at the adjacent Army posts.

Two new committees made their appearance during 1942: the Procurement and Assignment Committee, whose purpose was to procure physicians for military service and assign civilian physicians where needed; and the Emergency Medical Service under Civilian Defense. Dr. Herbert Burden was the chairman of this latter committee which accomplished much in organizing Stretcher Units, arranging for special courses in Advanced First Aid, establishment of a Casualty Station at the Sacramento County Hospital, staffed the various hospitals with physicians to care for patients in the event of a disaster; and made available over 900 pints of blood plasma for this service.

The Woman's Auxiliary meets on the same evenings as the County Society, and has been extremely coöperative in all the activities of the Society pertaining to the promotion of desirable public health, social welfare and any emergency war work.

H. L. Saverien,
Secretary.

Shasta County Medical Society

Following is the report of the Shasta-Trinity County Medical Society for the "Pre-Convention Bulletin."

The Shasta-Trinity County Medical Society has been holding regular monthly meetings except for the months of June, July, and August.

Eight of our members are now in the U. S. Army. A few doctors have moved to other communities. New members have just about balanced our losses.

We have not been fortunate enough to interest anyone in taking up the practice of eye, ear, nose and throat in this County. No other shortage of physicians is being felt here.

John E. Kirkpatrick,
Secretary.

Tehama County Medical Society

The following report I think will be satisfactory for the "Pre-Convention Bulletin."

The Tehama County Medical Society has an active membership of nine physicians and the meetings are held either in Red Bluff or Corning at the call of the President. Doctor R. I. Thompson, one of our members is in defense work in England and Doctor O. T. Wood, our Secretary, is on active duty in the Navy. All of the members have been coöperating with the local defense work. The County Hospital admits part-pay and full-pay patients.

R. G. Frey,
Secretary.

Yolo County Medical Society

The enclosed is a brief report from the Yolo County Medical Society.

During the past calendar year the Yolo County Medical Society had nine meetings. Our regular vacation period was July and August. We were fortunate to be able to obtain very good speakers for most of our meetings. All of the active members felt that the meetings were very profitable from an educational point of view.

Dr. James E. Parsons of Dixon was accepted as a new member of the Yolo County Medical Society. He is located in Solano County, but it is more convenient for him to attend the Yolo County Society meetings.

Doctors Babbin, Burns, Frost, Gray, Leivers and Porter were admitted as new members. At the close of the year we had seventeen active members, fifteen of whom live in Yolo County. There are now twelve members in the military service. This means that 40 per cent of our original membership are now serving their country in this capacity.

Since this is primarily an agricultural district, the farm labor problem is most acute. During the past harvesting season, 1,000 Mexican Nationals and 450 Navajo Indians were brought in to help ease the labor problem. Of the two groups, the Mexicans were the more difficult to take care of. There were two problems in handling them. One was the language difficulty, the other was the fact that they apparently were encouraged to come in for the most trifling complaints. The medical expenses for both groups was borne by the Agricultural Workers Health and Medical Association. At the present time there is a considerable acreage in Yolo County that is being planted with Guayule, and the government has under consideration a housing project for some of the workers who are to supervise this project. The medical care of these workers has not been clearly defined as yet.

Emery Leivers,
Secretary.

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties.

John W. Green, Vallejo, *Councilor.*

Humbodlt County Medical Society

In 1942, the Humboldt County Medical Society had a paid up membership of thirty-one. Four more of our members volunteered for service with the armed forces during the year, Dr. J. M. Brown, Dr. L. G. Kramar, Dr. M. J. Hoilien and Dr. Max Todd. One of our members, Dr. John Lane, was claimed by death. Dr. Ernest Giannotti, at the Scotia Hospital, applied for membership. Dr. Herbert C. James moved to Ferndale from Mendocino County to take over the practice of Dr. Morris Krutchkoff when the latter moved to Eureka.

Several educational films were shown before the Society during the year. Due to transportation difficulties because of war conditions we were unable to get as many outside speakers to address our Society as usual. Dr. John N. Chain, Medical Director for the Defense Council of Humboldt County, gave an educational lecture on the various steps taken by the defense council for the protection of this area. Educational programs sponsored by our Society on cancer and tuberculosis were continued.

The Woman's Auxiliary was very active during the year and rendered fine service to organized medicine on the different educational programs and also assisted in the distribution of literature to the various clubs throughout the County in an attempt to educate the public regarding the Basic Science Act.

Because of the great increase in the activity of the lumbering industry and the addition of shipyards in this area, the doctors remaining have been unusually busy.

We were served by three presidents during the year. Our president, Dr. Max Goodman, volunteered for military service early in the year and a few months later our vice-president, Dr. J. M. Brown, volunteered. Dr. Charles Faik, Sr., was then elected to finish out the term.

J. S. Woolford,
Secretary.

Marin County Medical Society

The Marin County Medical Society now has thirty active members. Twenty members are now in the army and navy. We have suffered no losses by death in the past year.

We have two osteopaths and several chiropractors who make a living, but little is heard about any of them.

The Society held eleven meetings during the year, always with a good attendance. The usual vacation months are June and July, but due to the war activities, we held a meeting each month. There are at least two eligible members in prospect. The C.P.S. project at Sausalito has several doctors employed.

The Marin County Society went on record as backing C.P.S. and so far the proposition is working out very nicely, so far as the doctors are concerned. All complain of having too much to do, but no epidemics have occurred. A large area on the West Coast has no doctor at present, with no prospects of one.

During the past year a new County Health Department has been installed. Doctor Irving D. Johnson is the new full-time health officer. He is getting things started and will, no doubt, fill a long needed want. The County has so many newcomers that health conditions have become a real problem. This shortage of doctors is being met without complaint by the present members who are determined to carry on.

CARL W. CLARK,
Secretary.

Mendocino-Lake Medical Society

To date, we have seventeen paid up members in our Society this year. There are ten men in the armed services—three in the navy, two in the army and five in the air force.

During this past year, we had three meetings and during 1943, we shall attempt to hold our meetings quarterly. Because of the transportation problem and the great distances involved in attending the meetings from all parts of the two counties, it is difficult to plan a definite program of meetings for the coming year.

LOUISE E. PETTY,
Secretary.

Napa County Medical Society

The Napa County Medical Society met regularly every month during 1942, with the exception of two summer months. The organization takes in practically every eligible member in the County of Napa.

Our active membership has been somewhat depleted by the enrollment in the military service of a rather sizeable proportion of the membership. Our membership consists of the men in general practice and the men in institutional practice—the county containing three large institutions, namely, the Napa State Hospital at Imola; the Veterans' Home at Yountville; and the St. Helena Sanitarium and Hospital, near St. Helena.

We believe, as an organization, that the members remaining on duty in the county can readily carry over the present emergency and produce satisfactory medical and surgical care for the people of the community and institutions, until the men who are in the armed services can be mustered out and returned home to us.

Our organization was recently saddened by the death of Doctor I. E. Charlesworth, Superintendent of the Napa State Hospital, and always a very active and loyal member of the Napa County Medical Society.

Members now in the armed service are enumerated as follows: George I. Dawson, of Napa; Walter H. Brignoli, of St. Helena; Robert W. Boggs, of St. Helena; C. Lyon Wood, of St. Helena; R. S. Rood, of Imola; John L. Pasmore, of Imola; Richard E. Argens, of Imola; D. B. Williams, of Veterans' Home; Floyd Hohnstein, of Veterans' Home; and Richard Heinz, of Veterans' Home.

M. M. BOOTH,
Secretary.

Siskiyou County Medical Society

The year 1942 was marked by the loss of five of our members—one, Dr. H. L. Vidricksen, our President, going into military service and four others moving to other locations. We hope, however, to bolster our membership which now stands at twelve, for we have three applications to be considered at our next meeting.

Only four meetings were held during the year. Dr. John Green and Dr. Dwight Murray graciously made the long special trip to attend one. On another, Dr. Robert Burns of the Woodland Clinic, conducted an interesting discussion on "Practical Urology." The other meetings were given over to the business of the Society.

A Woman's Auxiliary was organized in April, of this year.

F. W. MARTIN,
Secretary.

Solano County Medical Society

Solano County now has seventy-five licensed physicians and surgeons, who may be classified as follows:

Active members of Solano County Medical Society:
In practice, 40.
In armed forces, 5.
In public health work, 2.
Active nonmembers, most of whom are new residents of County:
In practice, 9.
In full-time C.P.S. work, 5.
In full-time public school work, 1.
Retired physicians, 5.
Licensed United States Naval Officers, who do not practice locally, 8.

In addition to this, we have recently lost two physicians by death—an honorary member retired, Dr. J. J. Hogan of Vallejo, and an active member, Dr. Frances Stolle of Dixon.

The Solano County Medical Society meets on the second Tuesday evening of each month, usually at the Hotel Casa de Vallejo. During the past year, a meeting has been held each of the twelve months of the year.

We have within the bounds of our Society the U. S. Naval Hospital at Mare Island, whence we have obtained great assistance in past years in programs and social activities, but this has necessarily been curtailed during the year 1942 by the national crisis.

The Solano County Medical Society has five of its members in active military service. The Society exempts such members from local dues.

The Procurement and Assignment Committee, under the direction of its Chairman, Dr. Ream S. Leachman, has done its utmost to stabilize and ultimately improve the present ratio of one physician to every 4,000 people.

The Society has a functioning Grievance Committee; a well organized Civilian Defense setup, with an adequate number of Emergency Hospitals well organized, equipped and staffed, operating directly under the Society's Civilian Defense Officer, Dr. Carlton C. Purviance, with an organized evacuation setup in charge of Dr. Gordon Bunney of Suisun.

The Society has encouraged, aided and supported the endeavor of the Woman's Auxiliary in the organization and operation of a Blood Bank, coöperating with the Civilian Defense Council and the County Medical Society in its operation. The Society wishes to extend an expression of its appreciation to and admiration of the members of the Auxiliary who have worked so untiringly to develop and make this unit a most important and integral part of our Civilian Defense program. Under the able guidance of Dr. D. B. Park, its scope of activity has extended still further and the plasma from the Vallejo Blood Bank is now doing its part in helping to save the lives of American boys among the Islands of the Pacific.

The rapid growth of this defense area to about six times its normal population in less than two years time, has placed tremendous strains on hospitalization locally, with the result that Hospitalization Committees of the County Society have spent a great deal of time trying to work out our problems. The condition might have been much more serious than it has become had it not been for the long hours of night work that these committees have indulged in to endeavor to accomplish something along these lines. Results of this work are now gradually materializing, and contracts have just been let for the construction of a 250-bed hospital in Vallejo by funds granted under the Lanham Act. The need for this institution is evident when you realize that 75 beds have been the maximum available for a town in excess of 110,000 people and almost daily no beds available at the County Hospital, situated at Fairfield. Among those who have devoted much time and hard work to this development, I want to mention our Councilor, Dr. John W. Green, and our Society President, Dr. Cary A. Snoddy.

The Society has no headquarters, no library and no regular bulletin, notices being mailed out from the Secretary's office.

The programs for the scientific meetings have been arranged by a committee of which Dr. A. J. Ryan is chairman. In this he has worked in direct harmony with the postgraduate committee and we have endeavored to provide programs in line with the work being carried on in all postgraduate sessions—dealing with the various elements of war surgery.

On January 20, Dr. Stuart C. Way spoke to the Society on "Skin Conditions of Interest to the General Practitioner."

On January 25, Dr. Charles Dukes met the physicians of Marin, Napa and Solano Counties, presenting rapidly developing details of Procurement and Assignment Work.

On February 17, Dr. George Warren Pierce presented "The Modern Treatment of Burns." This meeting was held with the Napa-Solano Dental Association and the Solano County Nurses' Association as our guests.

On March 10, Dr. Ralph C. Pendleton of Salt Lake City and Dr. Macey of the Mayo Foundation, presented other aspects and methods of the "Treatment of Burns."

On April 14, Dr. Edmund Butler spoke on "Injuries to Abdomen, including War Injuries."

On May 12, we enjoyed an extremely illuminating lecture on "War Gases," by Chauncey Leake.

On May 17, Dr. Henry Rogers met with us on Procurement and Assignment Work; Dr. Albert Larsen presented C.P.S. for our consideration in the housing units.

On May 20, at a special meeting, the matter of C.P.S. service was carefully studied by the Society.

On June 9, Glenn Bell spoke to the Society on "Shock." Harold Fletcher spoke on the subject of "Medical Service in the Housing Units."

On August 11, the Society enjoyed the Public Health Service's new films on "Syphilis."

On September 8, we were graced by the entire staff of C.M.A., Dr. Wm. Molony, President; Dr. Karl Schaupp, Dr. Henry Rogers, Dr. George H. Kress, Dr. A. E. Larsen, Dr. Dwight Murray, and Mr. John Hunton. At this meeting the Society voted to place C.P.S. in the first of the Housing Units.

On October 13, Dr. W. L. Shepard spoke on "Tuberculosis in Wartime."

On November 10, the Society received a report of the Nurse Kenny treatment of infantile paralysis from Dr. Charles Widenmann, whom the Society delegated for this work to the March of Dimes Committee.

On December 8, a social evening was enjoyed by the Society, which was punctuated by our Councilor, Dr. John W. Green, assuming the rôle of Santa Claus at a Josh Xmas tree.

To the practicing physicians of Solano County, each and every one of whom has been loyally doing his utmost throughout the long hours of the day (and frequently the night) as his mind goes back over the year. 1942, there are three things which indellibly impress themselves upon him and which furnish a beam upon the horizon which lies ahead:

1. The willingness of our guest speakers to do everything possible to give us the results of research combined with ripe experience to assist us day by day. The pleasant professional and social contacts so made will long be remembered.

2. The relocation of several new and specially trained men into our area to assist in carrying the present load. We still need a roentgenologist, an orthopedist and an urologist.

3. The present prospects of adequate hospitalization at some time in the future.

F. Burton Jones,
Secretary.

Sonoma County Medical Society

The membership of the Sonoma County Medical Society is now sixty-seven. One member died during the past year. Sixteen of our members are now serving in the armed forces. There are six eligible nonmembers in the County, but one of these physicians has applied for membership.

Twelve regular meetings were held last year. The usual vacation was dispensed with, due to the great number of problems coming up before the Society in connection with the war effort.

The Sonoma County Woman's Auxiliary has been continuing in their work.

The major project of this year for the County Medical Society was the organization and establishment of a local Blood Plasma Bank for the benefit of all patients in the hospitals of the County, and so that blood plasma would be available on short notice from the Bank for any patient who needs it. The only requirement is that these patients themselves, or through their friends or relatives, replace the blood used, and pay a small fee for the cost of producing new plasma. Members of the Association are quite enthusiastic about this new service.

The Association also has continued to maintain a weekly health talk on KSRO. A variety of medical programs were given during the year.

The Society has been active in organization of the Emergency Medical Service of Sonoma County and has to a man been giving service in trials and planning for medical care under Civilian Defense if necessary. This includes the establishment of a base hospital at the County Hospital, manned by fifteen members of the Medical Society.

E. D. Barnett,
Secretary.

Yuba-Sutter-Colusa County Medical Society

The Yuba-Sutter-Colusa County Medical Society reports as follows:

Mr. and Mrs. Curtis of the Rideout Memorial Hospital, were host and hostess to the Society at a dinner meeting at their home. At this meeting Dr. Burkland of Sacramento, presented a paper on "Gastro Intestinal Symptoms in Kidney Diseases." Also present were twelve officers from the Station Hospital at Camp Beale, as guests of the Society.

During the past year and a half, Drs. Miller, Swift, Hamilton, Kimmell, Morris, Parkinson, Delamere, Thunen, Oranduff and Didier have left the Yuba-Sutter area to join the Armed Forces. Because of the extreme shortage of doctors, and because of the tremendous burden placed on the few remaining doctors, it has been impossible to conduct regular meetings, at least with the hope of securing a good attendance.

The new officers for the year are: Dr. Lindstrum, President; Dr. Hoffman, Vice-President; Dr. Salopek, Secretary-Treasurer.

Much of the added burden is the result of work arising through the nearness of Camp Beale,—which includes caring for officers' wives and families, as well as enlisted men's wives and families, and civilian workers. The above mentioned camp uses Marysville physicians almost solely for their medical care.

The physicians in the community feel that the civilian population can be cared for even though the strain is almost beyond each man's capacity, and even though no replacements have been made, except in two instances. Dr. Lewis has arrived as eye, ear, nose and throat man from Santa Barbara and Dr. Thayer is assisting in diseases of women and children.

J. J. Salopek,
Secretary.

LOS ANGELES

(Continued from Page 203)

Steamship Service

Vessels of more than 200 steamship companies call at Los Angeles-Long Beach Harbor—52 maintain regular cargo-passenger schedules, providing service throughout the world. 44 tanker and 22 lumber companies operate regularly through this port, while vessels of more than 80 others call regularly for bunkers, supplies and to make repairs.

Population Growth

Year	*L. A. City*	*L. A. County*
1850	1,610	3,530
1860	4,385	11,333
1870	5,728	15,309
1880	11,183	33,381
1890	50,395	101,454
1900	102,479	170,298
1910	319,198	504,131
1915	475,367	815,000
1916	500,000	852,000
1917	533,595	875,000
1918	550,000	884,500
1919	563,000	910,474
1920	576,673	936,455
1921	660,251	1,086,408
1922	736,963	1,255,353
1923	802,358	1,378,685
1924	850,143	1,509,318
1925	1,014,622	1,864,733
1926	1,056,983	1,933,675
1927	1,079,789	1,996,507
1928	1,152,806	2,074,812
1929	1,206,764	2,196,195
1930	1,233,144	2,202,510
1931	1,255,809	2,278,580
1932	1,283,859	2,336,060
1933	1,281,266	2,308,870
1934	1,293,329	2,381,080
1935	1,294,600	2,389,680
1936	1,315,000	2,453,970
1937	1,372,000	2,609,270
1938	1,415,000	2,718,780
1939	1,442,000	2,738,390
1940	1,490,000	2,766,190
1941	1,554,000	2,830,000
1942	1,625,000	2,942,000

Population—Federal Census (1940)

City.....1,504,277 County.....2,785,643

(As of April 1, 1940)

Estimated Population on July 1, 1942

City.....1,661,000 County.....2,997,000

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EDITOR GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) Fresno 1943
F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER JOHN HUNTON
Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Change of Address.—Request for change of address should give both the old and new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

PRE-CONVENTION BULLETIN

Why the "Pre-Convention Bulletin" should be Scanned.—As in former years, the April issue of CALIFORNIA AND WESTERN MEDICINE consists of two parts: (1) the *Pre-Convention Bulletin,* and (2) C. and W. M. proper. The attention of members is called to the *Pre-Convention Bulletin,* since its perusal permits readers not only to familiarize themselves with the problems of organized medicine, but also to obtain an over-all understanding concerning the activities of the California Medical Association and its component county medical societies.

The officers of the State Association and the County Societies give generously in time and effort to promote plans designed for the betterment of the public health, and the maintenance of high standards in medical practice. Members who are officers usually are the recipients of the honors so bestowed, because, as a rule, they have conducted themselves in their relations with their fellows, in such manner that their respective organizations feel safe in placing the trusteeship of the profession's interests in their keeping. Contrary to the opinion held by some physicians, it is to be remembered that many officers are busily engaged with the responsibilities of private practice, so that the time set aside to conserve and develop the interests of organized medicine is not easily found. Yet, so great is the lure of work to be done, in implementation of the interests of the profession of medicine, that the time necessary for such service is gladly given. Even a hasty scanning of the many reports in the current issue of the *Pre-Convention Bulletin* is sufficient to permit one to understand why American Medicine, in spite of the many attacks directed against it, has been able to maintain its principles and methods. Readers are urged to take the small amount of time required to look over the reports, since an informed profession will make for unity and greater progress.

WELCOME LETTER FROM GOVERNOR EARL WARREN

Examining Physicians for Selective Service Boards.—When the Selective Service Boards were brought into being in 1941 by the then Governor of California, complications arose, here and there, because of the manner in which some examining

physicians had been appointed. In certain districts, for a time, the work was seriously handicapped.

It is gratifying to know that the present State Administration approaches the matter in different spirit, as may be noted from the following letter, received from Governor Earl Warren:

(COPY)

STATE OF CALIFORNIA

Governor's Office

EARL WARREN, *Governor*

Sacramento, February 15, 1943.

Dr. George H. Kress, Secretary,
California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Dr. Kress:

Examining Physicians serving with Selective Service Local Boards are nominated by the Governor for Presidential appointment, and Medical Advisory Boards are appointed by the Governor.

I plan to follow a procedure which in my opinion will maintain the Selective Service system in our State free from all considerations except those essential to the filling of these positions with the best possible personnel.

Briefly, I am asking the various County Medical Societies to shoulder the responsibility of making recommendations for these appointments.

I am doing this because these positions are a matter of community concern, and, therefore, selection should be left as much as possible in the hands of those thoroughly familiar with the profession and with local conditions.

It is not my intention to disturb existing personnel in these positions, or other personnel presently engaged in the administration of Selective Service in the State. My only purpose is to clarify the procedure for filling actual vacancies in these positions as they occur.

I am communicating with you as Secretary-Treasurer of the California Medical Association, trusting that you will be willing to assist by promulgating this plan among the various County Medical Societies and by working out such general rules as may be necessary to carry it out with uniform practice and in a manner that will be understood by all.

I am confident that the County Medical Societies will continue to shoulder this added responsibility as a patriotic duty.

Assuring you that I will appreciate whatever you and the California Medical Association may do to put this program into effect among the County Medical Societies, I am,

Sincerely,

(Signed) EARL WARREN, *Governor.*

EW:mg.

SELECTIVE SERVICE EXAMINERS RECEIVE DESERVED THANKS

Letters Expressing Appreciation for Services Rendered by Physicians Doing Selective Service Work.—No less pleasing than Governor Warren's letter, which appears above, is a communication received from the "National Headquarters—Selective Service System," from Director General Lewis B. Hershey, through Colonel L. G. Rowntree, Chief of the Medical Division, in which both General Hershey and Colonel Rowntree express the appreciation of their departments for the professional services rendered by physicians and dentists. The particular subject of the letter is "Medical Circular No. 3."

General Hershey addressed his communication as below.

(COPY)

March 1, 1943.

To: State Directors,
Local Boards,
Appeal Boards,
Medical Advisory Boards,
Examining Physicians and Dentists of Selective Service.

The purpose of this circular is to guide physicians and dentists in the preliminary physical examination of registrants *to the end that all selectees will be physically examined and processed locally in like manner.* The following pages furnish the reasons for the adoption of the present system of examination by Selective Service, the instructions covering the preliminary physical examination, section 623.33 (revised) of the regulations, and revised List of Defects (DSS Form 220). It is hoped that each examining physician and dentist will study carefully his personal copy of the circular—familiarize himself thoroughly with the details of the examination, as well as with the lists, and then adhere rigidly to the regulations. The objective is to disqualify all registrants locally who have manifestly disqualifying defects and forward all qualified registrants to the examining and induction station.

This Medical Circular No. 3 affords the welcomed opportunity to express to the examining physicians and dentists of the Selective Service System, the appreciation of this Headquarters for their loyal and valuable professional service which has proved of the utmost importance in helping the Nation to meet its wartime needs.

(Signed) LEWIS B. HERSHEY, *Director.*

* * *

The above Circular No. 3 came with the following covering letter, dated March 18, 1943:

(COPY)

Subject: Medical Circular No. 3

Dear Doctor Kress:

Enclosed please find Medical Circular No. 3 which is self-explanatory. It is the opinion of this headquarters that this circular will be of interest to you and your readers.

As you know, the demands on the medical profession are unbelievably great and the number of doctors entering the military service very large. Since Pearl Harbor the quotas have been increasingly large, thus the number of men to be examined each month is in proportion. Under the circumstances it is impossible for the examining physicians of Selective Service to carry out the complete physical examination on all registrants.

Medical Circular No. 3 sets forth the reasons for the adoption of the system employed; it also covers the Selective Service Regulations and the List of Manifestly Disqualifying Defects, Deficiencies, Disorders and Diseases.

Selective Service is much impressed with the devotion and the patriotism of its examining physicians and dentists. As you no doubt know these professional men in Selective Service are making the preliminary examination of registrants who are to be inducted into all branches of the military service. This represents a national service of great magnitude and importance.

Publication of this circular, or portions thereof, together with an editorial on the value of the service and appreciation of the work of the medical profession, might be very worthwhile.

For the Director,
(Signed) L. G. Rowntree,
(Colonel, Med.-Res.)
Chief, Medical Division.

* * *

Medical Profession is Happy at This Recognition.—California and Western Medicine, happy to comply with Colonel Rowntree's suggestion, calls to the attention of members of the California Medical Association the importance of Medical Circular No. 3, and reciprocates at the same time the appreciation of the California Medical Association for the kindly expressions of the Federal Departments — headed by General Hershey and Colonel Rowntree,—for their statements concerning the services rendered by the Medical Advisory Boards and Examining Physicians of Selective Service; the editor taking the liberty to italicize those portions of the communications.

* * *

Anent the subject of appreciation for services rendered by members of the medical profession, in both civilian and military activities, before and since the beginning of World War II, the attention of readers is once more directed to a series of items taken from the editorial columns of California newspapers, concerning the work of physicians, in which kindly and understanding presentations appear. For such, in this current issue, see page 255.

It is gratifying to learn that, in quarters where good opinion is of most value, the generous services so constantly given by members of the medical profession, are being recognized.

SURVEY OF C.P.S. MEDICAL SERVICE AND HOSPITALIZATION PLANS IS NOW BEING MADE IN CALIFORNIA

California and Western Medicine, in its March issue, on page 130, under Item 12 of the minutes of the C.M.A. Executive Committee meeting of February 7, 1943, presented a discussion relative to the employment of Mr. John Mannix of Michigan Medical Service, and in accordance with the action taken, he will begin his survey work in April. Mr. Mannix has also been given a place on the annual session program. Reference is made thereto, to remind members of the Association that the survey will be under way before the Annual Session convenes on May 2nd.

In connection with the above, mention may be made of a resolution adopted at the recent meeting of the Association of California Hospitals, in which coöperation for closer relationship between that organization and the California Medical Association—in furtherance of medical service and hospitalization plans of mutual interest—is emphasized.

It is heartening to know that the constituted authorities of the hospitals of California are working in harmonious coöperation with Organized Medicine. In days such as the present, there is increasing need for that kind of mutual and kindly approach and endeavor.

HOW SACRAMENTO DRUGGISTS PUBLICIZED PRESENT-DAY MEDICAL NEEDS

Coöperation Between Sacramento Druggists and Physicians.—The *Sacramento Bee,* of February 17th, printed a half-page announcement, paid for by some 27 druggists, to each of whom was assigned two inches of space for name, address, and telephone number. Above the names there was a 7 by 10 inch illuminated display, in which appeared the information below, concluding with a line in neat capital letters, "This Appeal Sponsored by the Following Sacramento Druggists":.

Mention is made of this advertisement because the druggists initiated the plan, in an effort to educate the citizens of Sacramento concerning their obligations to physicians in these somewhat disturbed times. The example set by the Sacramento druggists may suggest similar procedures in other communities.

Text of the announcement, which was modified from an item which had previously appeared in California and Western Medicine, follows:

Rationed Gas, Rationed Tires, Rationed Doctors!
DON'T
S A B O T A G E
Your Doctor's Time
Save Your Health and Your Doctor's Time

A large proportion of Sacramento's physicians have entered military service. Many more are preparing to go. Yet these "home front" physicians

are being required to carry a greatly increasing burden of work.

You and your family can help both to lighten this burden and to make sure that everyone will get the utmost benefit and safety from the limited medical service that will be available. Here's how:

1. Instead of asking the doctor to come to your home, go to his office when you can.
2. If a house visit is necessary, call the doctor before 8:30 in the morning or before 12:30 at noon, so he can plan his house calls efficiently.
3. Don't neglect to inform your doctor of the early signs of sickness. A timely visit to your doctor may prevent serious illness, numerous house calls—even hospitalization.
4. Be patient with your doctor if you have to wait in his office, or if he does not respond at once to your call. Remember that he is caring for many more patients than formerly, and he has only twenty-four hours in his day.

You and your neighbors on the "home front" won't suffer from lack of adequate medical care if we will all help the doctors carry their burden of extra service.

LANGLEY PORTER CLINIC, NEUROPSYCHIATRIC AND OTHER HOSPITALS

Deserved Honor.—Friends of Langley Porter, M. D., who served so many years as teacher and dean of the Medical School of the University of California, partook of the pride that was his due when the Neuropsychiatric Hospital, erected on the Medical Center grounds in San Francisco, was dedicated and given the name, Langley Porter Clinic. This new hospital and out-patient department will be in position to render excellent service to the people of the State.

It may be in order to offer the comment that it is the hope of physicians of California that the administrative officers of the Neuropsychiatric and other public hospitals will always keep in mind the desirability of not instituting methods of admittance and stay, that may be harmful to the interests of private medical practice, or to many other hospitals that are not supported by taxation, and which, for many years, have been rendering excellent service to the people of the State.

* * *

An Unusual Request from Federal Authorities.—At the time the above was written, on March 27th, the press in San Francisco gave publicity to a news item in which it was stated that the Federal "Office of Defense, Health and Welfare Services" was practically demanding that hospitals in San Francisco County,—by State law instituted and supported by taxation for the care of indigent citizens—be opened to pay-patients of the general public. (For items referred to, see in this issue, on pages 236 and 245.)

* * *

Concerning Projected Hospitals for the U. S. Public Health Service.—Information has also been received that Washington authorities are planning for hospital structures of permanent nature, to be erected in Pacific Slope States, the administration of which is to be under the auspices of the U. S. Department of Public Health.

The issues involved in the above are important to physicians, especially with reference to medical practice in the future. The subject is of sufficient moment to be worthy of consideration by the C.M.A. House of Delegates, when it convenes in annual session at Los Angeles, on May 2, 1943.

* * *

Medical Service as Proposed by the National Resources Planning Board.—At that time, also, the implications involved in the medical service proposals put forth in the "National Resources Planning Board," as submitted to Congress in President Roosevelt's message of March 10, 1943, may be worthy of attention.

Members of the C.M.A. House of Delegates, who have been studying these propositions, may wish to submit resolutions thereon, in order to facilitate further discussion. The time to consider such matters to best advantage, is in the beginning, not later.

INVALID DIETS AND FOOD RATIONING

A recent letter received from the "Food Distribution Administration" of the United States Department of Agriculture and signed by Russell M. Wilder, M. D., Chief of the Civilian Food Requirements Branch, calls attention to the rules concerned with diets for invalids. It is important that physicians and patients should know what are the procedures to be followed, in order to secure rationed foods in amounts or kind over and above the amounts available for other citizens.* The notice which follows gives such information:

(COPY)

INVALID DIETS AND FOOD RATIONING

Of interest to all who are concerned with diets for invalids is Ration Order 13, issued by the Office of Price Administration under date of February 9, 1943. This order covers all canned, dried, and frozen fruits and vegetables. Article II, Section 2.5 of the order reads as follows:

"Consumers who need more processed foods because of illness may apply for more points. (a) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two, may apply for additional points. The application must be made, on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more processed foods, the amounts and types he needs during the next two months, and why he cannot use unrationed foods instead.

(b) If the board finds that his health depends upon his getting more processed foods, and that he cannot

* Should difficulties arise in securing local board sanctions for special diets, it is requested that C.M.A. members inform the editor of CALIFORNIA AND WESTERN MEDICINE.

use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the next two months."

The application form referred to above, OPA Form R-315, is apt to be somewhat confusing to patients. It is titled "Sugar Special Purpose Application" and was developed primarily to meet the need for home canning. It is being used temporarily, until a more adequate form can be gotten out.

It is anticipated that the procedure indicated in Section 2.5 above may be changed somewhat in the future, in which case due notice will be provided.

ARMY NEEDS OFFICERS WITH SPECIALIZED MEDICAL TRAINING

Help the Army Secure these Officers.—On March 27th, a telephone message was received from the "San Francisco Officer Procurement Service" of the United States Army, through Mark C. Elworthy, Major, AUS, Officer in Charge, with the request that publicity be given to an official bulletin showing some current needs of the Surgeon General's Office.

Readers are requested to call to the attention of persons, who may be qualified, the need of enrollment for the various positions mentioned.

The text of the bulletin follows:

ARMY NEEDS OFFICERS WITH SPECIALIZED TRAINING

The Army is looking for trained specialists in the fields of Lay Hospital Administration, Biochemistry, Parasitology, Bacteriology, Medical Entomology, Medical Photography, and Sanitary Engineering.

In each of these fields properly qualified men may be commissioned as officers, usually in the grade of First Lieutenant, but in some cases in both lower and higher grades. The minimum necessary qualifications in the different classifications are:

Lay Hospital Administrators

Ages 25 to 50.

Three years' experience as a superintendent, Assistant Superintendent, director or business manager of a hospital of at least 100 beds.

Biochemists

Ages 25 to 59.

A high degree of skill in the field of clinical biochemistry. A Bachelor's degree in biochemistry plus four years' experience in medical biochemistry or a Master's degree plus two and one-half years' experience, or a Ph D. degree plus one year of experience.

A knowledge of toxicology.

Nutrition Officers

Ages 25 to 59.

Educational background and training in physiology, biochemistry or nutrition are preferred. Men with an educational background of zoology, pathology, botany food chemistry, animal husbandry or agricultural sciences will be considered provided they have had a reasonable number of courses in physiology and/or nutrition and/or biochemistry or have done research involving the effects of food and diet upon living organisms Men with a Ph D. or M.A. degree plus one year's experience, or B.A.'s or B S.'s with four years' experience in the field of nutritional research or related subjects will be considered.

Male dieticians will be considered providing they have the necessary scientific background.

Bacteriologists

Ages 25 to 59.

A knowledge of medical bacteriology, including methods of isolation of pathogenic bacteria and their identification and routine sanitary bacteriologic analysis of water and milk. College graduation plus four years' experience in medical bacteriology, or a Master's degree plus two and one-half years' experience, or a Ph.D. degree plus one year of experience.

Medical Entomologists

Ages 25 to 59.

Approximately four years' experience in the field of medical entomology.

Four years of college work leading to a Bachelor's degree in the field of medical entomology from a recognized institution. Training must have been along the lines of public health and must have included courses in medical entomology, medical bacteriology, medical protozoology and arthropod ecology and classification. The receipt of a Master's degree in entomology may be substituted for one and one-half years' experience and a Ph D. or equivalent degree with a major in medical entomology may be substituted for three of the four years of experience.

Medical Photographers

Ages 25 to 59.

College graduation in a related field.

Four years' experience in medical photography. An advanced degree in a related field may be substituted for part of the required experience.

Sanitary Engineers

Ages 25 to 59.

Approximately four years' experience in sanitary and public health engineering including two of the following activities:

Mosquito Control, Rodent Control, Water Supply, Sewage Treatment.

A Bachelor's degree in Civil, Sanitary or Chemical Engineering. The receipt of a Master's degree may be substituted for one and one-half years of the required experience and a Ph.D. degree for three of the required years.

Men on the active or reserve list of the United States Public Health Service are not eligible.

* * *

In all these classifications the draft status of applicants is immaterial and men classified for *limited service only* will be accepted.

Applicants who are interested and sincerely believe themselves fully qualified under the specifications, should address inquiries to the Officer Procurement District Office nearest their home.

Offices in the State of California are located as follows:

San Francisco Officer Procurement District, Room 328 Flood Building, 870 Market Street, San Francisco, California.

Los Angeles Officer Procurement District, 1418 United States Post Office and Courthouse Building, Los Angeles, California.

CALIFORNIA LEGISLATURE IS IN SESSION

Public Health Legislation Proposed at Sacramento—Readers who may not have noticed the report, are requested to turn to pages 134-137 of the March number of CALIFORNIA AND WEST-

ERN MEDICINE, and glance over the very large list of proposed laws which have relation to the interests of Public Health and Medical Practice.

A rapid survey of the long list there given, cannot do other than impress one with the heavy tasks which confront the C.M.A. Committee on Public Policy and Legislation in its work. (Doctor Dwight H. Murray, of Napa, Chairman.)

Physicians have cause to be grateful that the medical profession contains colleagues who are willing to interfere with the routine of their own busy, professional lives, and give wholehearted service to conserve and promote the best interests of scientific and organized medicine.

Fortunately, this 55th California Legislature will not be called upon to consider, as a "must-pass measure," a compulsory health insurance act. That does not mean, however, that the proponents of such legislation have given up the battle. On the contrary, it may be safely assumed that they are quietly marshalling their forces, to attain the same objectives, without resort to open battle. Wherefore, it behooves the medical profession to be as much on the alert, as in the past.

EDITORIAL COMMENT†

COMPLEXITY OF SERUM COMPLEMENT

The time is rapidly approaching when physicians and laboratory technicians must familiarize themselves with the clinical implications of the newer knowledge of the chemical nature of "alexin" or "serum complement." A typical example of recent advances is contained in a report by Pillemer[1] and his coworkers of the Institute of Pathology, Western Reserve University, of the four complementogenic factors active in specific serum hemolysis.

About fifty years ago it was shown by Buchanan, Bordet and others that cytolytic serums are inactivated if heated to 56° C for 30 minutes, and that such heated serums can be reactivated by the addition of normal serum. The nonspecific thermolabile factor or group of factors in normal serum bringing about this reactivation was named "alexin" by Bordet, and "serum complement" by Ehrlich. This thermolabile component or group of components was pictured by both investigators as a pan-immunizing defensive enzyme, causing lysis of bacteria or erythrocytes "sensitized" by the thermostable specific immune body ("amboceptor"). Complement, therefore, was assumed to be a single chemical substance, presumably protein in nature. This assumption has determined the terminology and clinical logic for the last half century.

The first serious challenge to this unitarian concept was about thirty years ago, when it was shown by a number of serologists that complement can be separated into two components, a globulin and an albumin fraction. Neither of these substances is in itself active, but full activity can be restored by reuniting these two proteins in their original proportions. Alexin or complement thus became a complex globulin-albumin conjugate, a globulin fraction ("mid-piece") capable of uniting directly with sensitized cells, to which was attached an albumin fraction ("end-piece"), incapable of direct union. Both "mid-piece" and "end-piece" were apparently denatured by heat.

This concept of complement as two conjugated proteins had little or no effect on clinical logic. A third essential complementogenic factor, however, was subsequently demonstrated by Coca,[2] who found that complement can be inactivated by adsorption or absorption on yeast, without injury to either the mid-piece or end-piece. After yeast inactivation the serum can be fully reactivated by addition of the thermostable fraction of normal serum. Ten years later a fourth essential complementogenic factor was demonstrated by Gordon,[3] a heat-stable component removed, destroyed or denatured by treatment with ammonia or ammonium salts.

Numerous possible clinical applications of the new complement components were implied in studies of the "hereditary absence of complement" in certain strains of guinea pigs. These strains are hyper-susceptible to practically all microbic infections, and can be reared only with most scrupulous hygienic care. It was shown by Hyde[4] that this hereditary serum deficiency is due solely to a lack of the third or yeast-adsorbed complement component, the other complematogenic factors being both qualitatively and quantitatively normal. Incidentally, Hyde showed that this third component does not pass through the placenta, that its lack of formation is due to a single recessive gene, and that failure to allow for the third component in heat-inactivated sera may introduce serious errors in routine clinical diagnosis.

Since then numerous biochemists have attempted to determine the method of action of each of the four recognized complementogenic components. A simplified terminology was suggested by Pillemer, Heidelberger[5] and others: C'1, C'2, C'3, and C'4 in place of the "mid-piece," "end-piece," "third component," and "fourth component" of earlier investigators. Pillemer and his colleagues found no evidence that any one of these components is able to unite directly with specific antibody ("amboceptor"), nor with non-sensitized cells. After "amboceptor" enters into primary combination with the red cells, however, the surface of the resulting antiserum-cell aggregate has a selective affinity for C'1, C'2 and C'4. C'1 is able to combine directly with these sensitized cells, while C'4 does not combine in the absence of C'1. C'1, therefore, apparently functions as a secondary sensitizer. Although C'1 is essential for C'4 absorption, an excess of C'1 may block absorption and thus function as an anti-complement.

The latest electrophoretic diagrams[5] suggest that C'1 and C'2 each consists of a mixture of four or more proteins, the essential fraction in each complex being still undetermined. After

adsorption of C'1, C'2 and C'4 the sensitized cells become susceptible to C'3, which is apparently a catalyst, not fixed by the cells and not used up in the process of hemolysis.

These results are typical of conclusions previously drawn by the same authors from a study of complement fixation[6] and specific precipitin reactions.[7] The tentative suggestion that at least one of the newly recognized complement components may be a derivative of certain vitamins, or is in some unknown way linked with sex-hormones, is perhaps prophetic of futural clinical implications of the newer knowledge. The relation of the newer complexities to problems of blood or plasma transfusion has not yet been adequately studied.

P. O. Box 51.

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Stanford University.

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A NEW TRANSFUSION HAZARD?

While making serological studies of transplanted rabbit cancers, Kidd and Friedewald[1] of the Rockefeller Institute noted that the serum of a normal rabbit often fixes complement in mixtures with saline extracts of its own tissue. They conclude from this that there is a natural antigen-antibody relationship between serum and certain fixed tissue components, somewhat analogous to the relationship now recognized between type specific hemagglutinins and red blood cells.

The test antigens used by the Rockefeller Institute immunologists were made from normal rabbit tissues. These were removed with aseptic precautions and used either fresh or after preservation in the frozen state (-22°C). The tissues were first ground with sand and the resulting paste suspended in a measured volume of physiological salt solution. The suspensions were afterwards freed from cellular débris by 20 minutes' low-speed centrifugation (4400 r.p.m.). The resulting slightly to moderately opalescent supernatant fluids varied in their complement-fixing titers according to their tissues of origin. Kidney extracts for example usually gave complement fixation (++++ reactions) when tested in dilutions as high as 1:320. Lung extracts gave similar reactions only in dilutions as high as 1:80, splenic extracts at 1:40, and heart muscle at 1:20, extracts of skeletal muscles being wholly inactive.

The initial opalescent extracts were subject for one hour to high-speed centrifugation (25,000 r.p.m.) and the resulting ultrasediment resuspended in phosphate buffer solution. This resuspension contained all of the reacting substances of the original crude extract, practically no reacting material remaining in the clear supernatant fluid. Kidd and his associates did not attempt to determine the nature of this ultrasediment, though Henle and Chambers[2] had previously shown by microscopical and tinctorial methods that such ultrasediments are presumably composed mainly of mitochondria. If we accept this conclusion, the complement-fixing property of normal rabbit serum would be pictured as due to an anti-mitochondrial antibody normally present in rabbit serum. The fact that the active component resists heating to 56°C, but is destroyed at 65°C, and that it can be salted out with ammonium sulfate confirms its antibody nature.

Kidd and Friedewald concerned themselves mainly in devising methods to prevent interference of their new complement-fixing antibody in routine virus and cancer research. Nevertheless many of their data are of suggestive clinical interest. This is particularly true of the absence of the new anti-mitochondrial antibody in the serum of rabbits less than one month old, suggesting that the new antibody may possibly function as an adult growth inhibitor. Marked difference in titer were noted in different strains or breeds of rabbits, one rabbit giving a ++++ complement-fixation reaction when its serum is tested in dilutions as high as 1:32, while other rabbits require a concentration as high as 1:2 for a similar reaction. Many serums are wholly inactive. This suggests the possibility that a high-titer pregnant mother might inhibit or modify the growth of its carried embryo by transplacental passage of the new antibody, a phenomenon somewhat analogous to that now recognized for the anti-Rh factor. Of even more interest is the suggested possibility of a new transfusion toxicity, particularly in the use of high-titer donors and low-titer or negative recipients. While acute anaphylactic shock would presumably not take place due to the intracellular location of the reacting antigen, other less dramatic reactions are by no means ruled out. Such speculative hazards will undoubtedly be the subject of future experimental study.

Meanwhile, the discovery of a new, and previously unsuspected natural antibody reacting specifically with fixed tissue intracellular granules (presumably mitochondria), is of wide biological interest, particularly since the kidney, liver, brain and testicle are among the organs most highly susceptible to this new serum factor. A basic discovery of this type may well initiate a new era in clinical theory and practice, similar to that initiated by Landsteiner's demonstration of hereditary blood groups.

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REFERENCES

For References to Article, "A New Transfusion Hazard," see page 227.

ORIGINAL ARTICLES

Scientific and General

HOSPITALS AND MEDICAL PRACTICE*

HOW PHYSICIANS AND HOSPITALS MAY RENDER BEST SERVICE DURING THE DURATION

WILLIAM R. MOLONY, SR., M.D.
Los Angeles

THE progress in the practice of medicine, and of hospital service and care, during the past fifty years has been so gradual that a great change has taken place without those associated realizing its extent.

My early recollection of hospitals goes back to the nineties when, in Los Angeles, there were but four hospitals: the Sisters, the Good Samaritan, the French, and the County Hospital. There were several small hospitals or sanitariums owned by doctors and nurses—from some of which was developed the institution known as a stock company hospital. These were mainly doctor-owned hospitals, and contributed much to the advance of hospital care, while, incidentally, they rendered greater or less financial returns to the stockholders.

As the years rolled on and replacements, improvements and the ever-increasing demands for new equipment became more frequent and pressing, the enthusiasm of the stockholders waned and a way was sought to get out of a condition that was fast becoming a white elephant, a burden and a headache.

Gradually these privately-owned stock company hospitals passed into the hands of religious and other groups, whose purpose in acquiring and operating a hospital was the higher and more laudable one of rendering service to the sick and afflicted.

This phase of hospital ownership has passed, and the day of the hospital operated mainly for profit is gone and I hope never will rturn.

It is related that, in the early days of San Francisco, a well-known physician owned and operated a hospital. It was well conducted—had a splendid reputation and was apparently quite successful. In the declining years of his life he was wont to meet in one of the city's well-known clubs with several old friends. One evening, after dinner, the conversation got around to the subject as to the happiest days of their lives. One person spoke of his great stock success, another his wedding day, still another a great honor, and so on. The doctor had not contributed his observation, was, in fact, rather quiet and thoughtful. He, too, was asked to tell what he considered the happiest day of his life; when he replied that April 18, 1906 was the happy day. Several cried out, in astonishment: "Why doctor, that was the day of the great fire." "I know," he replied, "that was the day my hospital burned down!"

PRIVATELY-OWNED HOSPITALS OF FORMER DAYS

The early, privately-owned hospitals provided room and board, nursing, quarters and equipment for surgery, and other incidentals as aids to the practice of medicine.

Very meager records were kept, laboratory procedures were elementary, and little or no supervision was given to the type and quality of the work of the attending physician. A training school for nurses was maintained, but even this department was operated with an eye to profit. The special nurses were usually girls in training, and the pay for their services went into the hospital coffers. It was not unusual for these girls to be on duty 24 hours a day; they had a cot in the patient's room, and made out the best they could. This pernicious practice has long been abolished, and rightly so. Yet, as the shortage of nurses becomes more and more acute, it will not be amiss for them to realize that they, too, may have to adjust themselves to the needs of the War Program.

MUTUAL NEEDS OF PHYSICIANS AND HOSPITALS

There was a time when the hospitals needed the support of physicians in order to make ends meet, and offered many and sundry inducements to attract medical practitioners to use the hospitals. This has changed. The physician and the hospital need each other. For, without the facilities of the modern hospital a physician would find it difficult to carry on the practice of medicine. He, therefore, should value most highly the privilege of being on the staff and of having the facilities of the hospital at his disposal for the care of the sick under his care.

I have always cherished my hospital associations and have been most grateful to the Sisters for having extended to me the many benefits of the hospital.

CHANGES BROUGHT INTO BEING BY WARTIME CONDITIONS

This leads me to the discussion of the subject, "What can the physician do in wartime in order to conserve the facilities, equipment and services of the hospital, that more may be accomplished and provision made for the care of a greater number of patients?"

We are in the midst of a terrible war, with the country being geared to an all-war effort. In addition to the large number of doctors, dentists and nurses who have already enlisted in the armed forces, there will be taken this year from the medical profession of this State the staggering additional number of nearly 1,200 physicians: 761 will come from Los Angeles and Orange Counties; 349 will come from San Francisco County; and 33 from the rest of the State.

* Address. By Invitation. Before the annual session of the Association of California Hospitals, in Oakland, on February 24, 1943.

This is bound to make a shortage of doctors but not a serious one, unless we are confronted with an epidemic. Necessary steps and adjustments have been and are continually being made for the care of the so-called distressed areas.

While it is comparatively easy to shift and adjust our "doctor power," it is most difficult to add to our hospital facilities and equipment. It is here that the doctor can be most helpful. Indeed, he not only can be, but he must be!

In California, living as we are on the long, exposed western front looking out on the broad Pacific upon which our powerful enemy has been waging a war tuned to the purpose of destroying all that we hold dear, we must be ready and prepared for any emergency.

The departure of our physicians during the past 18 months has been timed so that, from week to week, there has been a gradual adjustment of patient care; patients and families finding new contacts, and doctors still in civilian practice, taking on more work and changing their hours and activities to meet these new responsibilities. If, then, the commissioning of medical men during 1943 is carried on in this same manner, there undoubtedly will be a continuation of adjustment of the patient load.

The calamity of a sudden disaster, whether of civilian or military origin, of a widespread epidemic or other emergency, will tax the resources of the remaining physicians, and also, the hospitals. In anticipation of any such condition, there has been set up in this State a most comprehensive plan, the direction of which is in charge of competent medical and hospital experts.

We are confronted with a shortage of hospital beds, as well as a shortage of nurses and other personnel. Replacements of equipment, instruments, medical and chemical supplies are becoming more difficult.

Hospitals, due to the rapidly advancing costs of foods, wages and supplies of every sort, have been compelled to raise their rates and charges to the point that is alarming both to the patient and the doctor. Unless drastic changes are made in the way of sharp curtailment of services, these rates and charges will have to go higher, with the result that the burden will be more than the average patient can bear and thus may be the entering wedge for governmental agencies to extend their activities into the private practice of hospital and medical care.

RÔLE OF THE PHYSICIAN IN THE HOSPITAL PROBLEM

What can the doctor do to help solve this problem? I believe that all of the men using the hospital must become war-minded in the sense that a determined effort be made to eliminate all special services an dbe satisfied with bed-rock essential care.

The unprecedented prosperity of the average man and woman who for years has been in almost dire need, only adds to our difficulties. These people now have ample means to pay for extra and special services and accommodations, and they want service. Regardless of this demand, the physician should be firm and hew to the line. The doctor must impress upon his patient that hospital rooms are scarce, that nurses are not plentiful. and that they must coöperate in a way that will distribute the benefits of hospital care to as many as possible. We should discourage the use of special nurses except for those patients where special care is absolutely and urgently needed. Even in these cases it is often possible to use but one or two nurses during the twenty-four hours.

It is especially important that the patient who has ample means and can easily afford the luxury of special nurses should, where the patient's condition is not serious, be denied the use of special nurses.

If an extreme shortage of nurses should come, there is no good reason why the nursing organization cannot meet this emergency, by splitting the hours for special needs, possibly extending the hours, and making any other changes that conditions warrant.

If a real shortage of nurses prevails in the United States, it is quite possible that certain governmental agencies will propose that facilities be established for the training of nurses. This course will be streamlined and compact. When the war is over there will be thousands and thousands of nurses available and no place to use them. Nurses should seriously consider this problem, and do their share in streamlining and conserving medical and hospital care.

In a hospital I recently saw a poster with the heading, "Six Ways to Save Catgut." I could add another: "Have the Doctor Buy His Own Catgut."

each vacancy.

If the doctor really wants to help in streamlining service, he can easily do so. Simply be firm and impress upon each patient to be thankful for a hospital bed, and that there is a waiting list for

In the average-sized hospital a great saving can be made in supplies; thus, in using less gauze, adhesive, towels, dressings and rubber gloves. Gloves are scarce as well as expensive, and should be handled carefully, and many times, their use can be easily and safely dispensed with.

Then about diet. The important thing is to see that the patient has a well-balanced nourishing diet. This can be accomplished by using the commoner foods which are still obtainable, and eliminating special dishes which are ornamental but not particularly nutritious. Special diets, special beverages and services at odd and irregular hours for the average patient can be avoided. This service takes up a lot of time of the nurses and of the maids.

Concerning objections and complaints of the patients, the doctor can be of real service. He can easily explain the reason why special diets and services cannot be had. He should be satisfied with the equipment, instruments, facilities and

services available. He should realize that replacements cannot be had and he should be glad to have the use of what is on hand.

Some years ago your speaker, and his wife, was in San Francisco and had, as guests to dinner, a couple who were formerly neighbors in Los Angeles. They had had severe financial reverses, and our guest's wife was complaining about having to wash the dishes. Her husband chimed in and said that she ought to be glad that she had dishes to wash!

DEPARTMENT SERVICES MUST BE CURTAILED

The x-ray departments are in some difficulty. The specially-trained personnel are constantly being taken by the Army and Navy, defense plants and by medical groups. New equipment is out for the Duration and, as said before, new prosperity has added to the number of hospital patients.

It has been said that if certain doctors would take a good history, make a careful examination before deciding to have a complete x-ray examination made, such as a G.I., G.B., spine, pelvis, G.U., etc., the x-ray load would be cut at least 20 per cent. It is somewhat of a short-cut to a diagnosis when a patient comes in with a history of a prolonged dyspepsia, upper abdominal distress, obscure chest and back symptoms to send him in for an examination, hoping that the expert roentgenologist will make the diagnosis and save the doctor a lot of work.

X-ray emergency service at night, Sundays and holidays should not be ordered unless the results are needed immediately. Too often the film is not looked at until the next day.

Then there is the intravenous service—glucose, normal saline, plasma blood, and all kinds of medications and tests. If these are urgently needed, they should by all means be used, and as many times as may be indicated, regardless of the time and labor. However, if the attending physician will supply his patient with enough fluid and sugar during the twenty-four hours before surgery, it will not be necessary to resort to the intravenous two or three times during the twenty-four postoperative hours. Fluids can be administered very satisfactorily in other ways, without taking up the time of a nurse and doctor.

Laboratory work, in the way of blood chemistry and chemical examination of fluids, is necessary and very often most important, and should be done. However, during this wartime many such examinations can be dispensed with, with profit to both the patient and the hospital.

Many types of ultra-modern, scientific medical, surgical and obstetrical practices, while very satisfactory in peacetime, can with very little loss be put aside for the Duration.

As is well-known, every pharmaceutical house has a long list of drugs, specialties, hormones and vitamins under its own special name. This is confusing to the nurses and multiplies unnecessarily the expense of medication. Steps should be taken to streamline and simplify these items, and save the time of nurses and the staff.

The physician should refrain from calling for or asking for new and special instruments. If a favorite instrument is not available, the physician should be patient and get along with what is on hand. He should be as considerate as possible with the surgery department; thus, be prompt, and proceed with his work without delay.

Economies with materials such as sutures, dressings, linen, and gloves, as has been said, will be most helpful. Full coöperation with the nursing staff, in carrying out time-saving procedure, will be appreciated.

The introduction and use of complicated procedures in the practice of surgery, medicine, obstetrics and orthopedics should be put off for the Duration. For example, the continuous caudal anesthesia in obstetrics. This may prove to be a satisfactory procedure in selected cases, but at best it consumes a lot of time, which could be devoted to other patients.

RECORD SYSTEMS

The great bone of contention and the source of continual irritation, however, is the matter of records.

There should be no argument against a system of adequate records—the question is: "What is an adequate record?" Some want the record to be all inclusive, a sort of encyclopedia. Others advocate the most meager and skeletonized record. There is a happy medium which should suffice. The important thing is to have a record simplified so that physicians will use it and complete it.

The Council on Medical Education and Hospitals of the American Medical Association is the controlling agency representing and speaking for the medical profession in its relation to hospital administration. Other groups not responsible to the American Medical Association have usurped this prerogative and have put pressure upon hospitals regarding standards, records and procedures which, while laudable in the main, should come from the Council of the American Medical Association. This makes confusion and at this time only adds to the work and difficulties of the physician and hospital.

The scarcity of interns and residents has thrown the work of history-writing upon the busy practitioner. If too much detail is demanded, little will be done.

VISITORS AND FLOWERS

What can be done about visitors? To prohibit them would be a hardship and create dissatisfaction. The doctor can cut down this visitor-load by forbidding visitors for the first week, and very few therafter.

Flowers, while bringing happiness to the patients, presents at the same time a real problem. The care of flowers costs time and money. It may be necessary to prohibit flowers in the hospital.

In peacetime, visitors are restricted to the

nursery and maternity floors, and to the surgery. Surely in wartime anything that helps to cut out the frills and special luxuries, that have gradually crept into hospital care, should have the wholehearted support of the physician. If the shortage of beds and nurses becomes very acute, it will be necessary to shorten the stay of each patient. Beds should not be occupied by rest-cure patients, by permanent boarders, by patients with a slight cold, or similar types. The obstetric patients can be sent home early. The uncomplicated surgical patient can be sent home by ambulance.

A suggestion is made that the Association of Hospitals in any given locality could make a survey to determine how many small hospitals, sanitaria and rest-homes might be accredited and made available to receive convalescent patients. This would operate to make available more hospital beds and effect quite a saving to the patient.

The busy physician who is already overburdened may object as more calls will have to be made at home; but if the beds are needed for other sick patients, there may be no other way out.

Let the doctor attend to the practice of medicine, and have the hospital confine itself to hospital service.

Any tendency upon the part of the hospital to render or countenance any service which, by law or medical ethics, is generally construed as the practice of medicine, should be discouraged. For example: The practice of anesthesia is a branch of medicine. In the organization of the American Medical Association, anesthesia has a section, as have surgery and obstetrics. Regardless of the specious pleas of those who are in favor of, and who employ lay anesthetists, the practice of this branch of medicine should be limited to Doctors of Medicine.

IN CONCLUSION

We must not forget that we have a job to do. We are committed to the principle of the private practice of medicine, to the *patient-doctor relationship*, and if we are to maintain the American way of life and of medical practice, we must do our share in coöperation with the hospital to give good care to the patient and, at the same time, keep down the rapidly-rising cost of sickness.

1930 Wilshire Boulevard.

If one continues to ply one's mind, growth ensues, even in the years formerly supposed to be marked by stagnation and decay. To foster this growth one must not trust too much to the casual gains of every day work and experience. One must put forth well directed efforts. Merely to maintain one's status is not enough. He who is satisfied to stand still will soon slip backward. To grow one must go on learning. So it has come about that education, formerly thought to be an activity limited to the days of one's youth, is now seen in one form or another to be desirable in all periods of life. Thus one continues to improve; thus one keeps young.—Leon J. Richardson.

WAR SURGERY*

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THIS subject of war surgery which has been assigned to me covers a field so large that I must of necessity limit myself to those subjects in which I am, as an orthopedist, particularly interested. During a recent trip to England, I was fortunate enough to have charge of the American Hospital in Britain for over six months. This fact rather, than any special knowledge of my subject that I may have, undoubtedly influenced your program committee to extend to me their flattering invitation to be here with you. With the literature so full of articles dealing with first-hand experiences, and many in this audience qualified to speak authoritatively on all branches of war surgery, I feel somewhat apologetic in appearing before you. But I will, nevertheless, endeavor to emphasize some of the factors that seem particularly important.

War surgery, in the sense that is generally understood, is fundamentally nothing more or less than the surgery of trauma, carried out under circumstances and conditions, and frequently far from ideal and, may be, ghastly and almost impossible to cope with. However, the underlying principles of surgery as practiced in times of peace, still hold good, and if the best possible work is to be done, these fundamentals must be thoroughly ingrained in individuals called upon to serve. No rule of "thumb" can be applied to every particular case, and surgical judgment is vital, not only in the active treatment of that case, but also in the picking of the time and place of that treatment, where this is possible. Many factors must be considered, and some of these will be discussed as we go along.

PROCEDURES IN WORLD WAR I

With a comparatively fixed front line as was seen in World War I, where the danger zone was narrow and attacks by airplanes were rare, the wounded could usually be evacuated back through the sorting of casualty clearing stations, evacuation hospitals, mobile hospitals and other units where the necessary treatment could be carried out. And the severely injured might be kept as long as necessary to make removal to a base hospital safe. Fractured femurs were sewn up in bulken frames only a few miles behind the front lines, and wards were filled with patients who could not be evacuated for weeks following their injuries. Working in hospitals, the surgeons, although severely pushed, could carry out almost ideally their necessary work with the excellent results that we all know. With modern warfare, however, the picture is different, of course. The fighting may be many miles in depth and there is practically no limit to the areas which can be

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bombed. Under these circumstances, the care of the wounded at the so-called front must frequently be modified, and the surgeon must decide whether immediate evacuation, if possible, even with the delay in adequate treatment is not better, than the surgery that can be done before evacuation. I have seen, in not a few cases, where incomplete and hurried surgery probably did much more harm than would have the few extra hours' delay during which the patient could have been transported to a safer and better-equipped hospital or environment, and where the most accepted treatment could be carried out properly.

SURGERY IN BOMBED CITIES

The use of the sulfa drugs enters the picture here, but will be discussed a little later. This point of fresh surgery if done, should also be considered when working in bombed areas in cities. Here there are always hospitals within a few miles, and the first aid and casualty station treatment should be limited to life-saving treatment. The use of morphine in large doses for pain, temporary splinting of fractures and the major surgical work left for the hospital staff. There is little or no use for motorized mobile surgical units in and around cities with adequate hospitals, as has been amply demonstrated in Great Britain. But these hospitals in areas subject to severe and frequent bombing must be kept ready for new casualties. And, this means that evacuation of all possible cases to institutions in the country or outside the area must be rapid. In some places in England, 60 per cent of the beds are supposed to be available each night, and with civil surgery still necessary the various problems which arise as a result of this can readily be seen. Elective surgery under these circumstances should be sent to the outside areas, and cases operated upon there rather than run the risk of possibly too early postoperative evacuation. I saw one convoy of patients come into the British side of the hospital where we were working which consisted of postoperative hernias, knee cartilages, and similar cases, all of whom had been operated upon within a week and some one day before. The staff of the hospital from which these men came had been overanxious to keep busy, and their patients had suffered accordingly when evacuation was ordered.

The compound fractures that we saw which came from London and the South Coast were treated, on the whole, very satisfactorily. Debridement, so well done, sulfanilamide placed in the wounds, and the closed plaster technique used were feasible. The results were definitely better, I believe, than in similar cases during the last war, and gas infection was at a minimum. The closed plaster method of Orr and Trueta has certainly demonstrated its usefulness in compound fractures. Like all methods in surgery it is not automatic, a certain amount of knowledge on the part of the surgeon must be behind its use, if good results are to be obtained. Unfortunately, this has not always been the case and the violent criticism which the French surgeons and others have made of Trueta's work cannot be directed logically at the work itself, but only at the surgeon performing that work. Even then a certain amount of charity must temper one's judgment when the conditions under which many of these men were working are brought into the picture. The method has been used by so many of us for so many years in civilian practice that we were not surprised at the results published by Trueta, or for that matter at the bad results observed in the wounded who escaped to France from Spain. After all, it is highly probable the majority of these latter were better off than with any other treatment that could have been given under the circumstances, and they were mobile as a result of the plaster of paris fixation and were able to escape which would have been impossible with a treatment like suspended traction.

The method is applicable in fresh and older cases alike and consists, as you know, primarily of a complete debridement of the wound. Apparently, the lack of this complete debridement is a point upon which most of the failures can be blamed as far as infection is concerned. However, there is ample evidence to show that even an infected wound will do better and the infection be limitedly locally with complete fixation; under the stress of many casualties, it might be better to place cases in plaster with no cleansing of the wound, but with pain and shock controlled and evacuation possible, rather than do incomplete debridements. One must also decide in this connection whether complete and proper treatment should be carried out at the necessary expense of others, and if so, what is the best treatment for the remaining group. We cannot be too critical of any man's work until we know the circumstances surrounding that work. Barnes, at Oxford, and many others have shown that complete immobilization of a part in plaster of paris causes complete stasis of the lymph flow and as infection travels, mainly by the lymph ducts, and infection in a wound will be confined to that local area with complete fixation which, of course, experimentally bears out all that the plaster fixation of Orr and Trueta have shown clinically.

Ideally, the debridement of a compound fracture or of a bad wound must be complete, with the removal of all dirt tissue such as clothes, metal, and stone, etc. Following this Trueta packs the part with dry gauze and this is the part in plaster paris, the fracture at present being adjusted as accurately as possible. The casing is left in place as long as possible, so as to allow healing to progress, in spite of the fearful stench that still develops, although there is remarkably little discharge in the cases seen early and thoroughly debrided. Padding can be placed over boney prominences, to minimize the danger of pressure sores, if desired, but otherwise the plaster is unpadded. With newer plaster technique, sad complications, due to pressure or influence

with circulation, develop, but they are preventable with a little care on the part of the surgeon. There are other obvious drawbacks to this method, most of which can be easily overcome by changes in the technique without any change in the underlying principles. Vaseline gauze is advocated by Orr and it always seemed to me to be better than the dry gauze packing of Trueta. And, after I have struggled a few times to dissect out a dry pack which has become an integral part of the patient, I was sure of my conclusions. If anyone has ever tried to take out a large piece of dry gauze that had been placed in the wound and left in place for several weeks, the granulations forming through it and then organizing, he will realize what I mean.

A further modification of the original method, Jensen has definitely shown in his series of cases that the implantation of sulfanilamide into the wounds of compound fractures, after debridement has decreased the incidents of infection to only slightly over three per cent. The experience of the English and more recently our own forces has borne this out.

A packing which some of us have used with success is made of gauze impregnated with cod liver oil ointment in which sulfanilamide and sulfathiazole have been mixed. This appears to be very efficient in old infected wounds also.

SULFA DRUGS AS AIDS

Where adequate local treatment must be delayed in wartime, due to many conceivable factors, there can be no doubt that the sulfa drugs used by mouth and local implantation can alone prevent many infections and save many lives. The local irritation to the tissues in the wound which we know to be present is apparently more than compensated for by the bacteriostatic action of the drugs, but certainly large amounts are not needed as the solubility even of sulfanilamide is very low. Sulfathiazole is so insoluble that I have seen so many wounds with plaques and masses of what appeared to be plaster of paris particles in them even weeks after introduction of the powder, and it is evident that this condition must interfere with healing.

Large quantities of the sulfa drugs should not then be implanted locally, as no good can come from their excessive use and definite harm might result, not to mention conservation of the drugs. Large doses have been used locally, of course, with no apparent bad result, and we had one compound patella which came to us after a primary excision of the bone and a primary debridement of the knee joint, with a note that 22 grams of sulfanilamide had been placed in the wound before doing the primary closure. The wound was healed perfectly, and the plaster was removed three weeks later; but one wonders if quicker and freer motion in the knee might not have been obtained if the irritative action of the excessive amount of sulfanilamide had not been added to the trauma itself.

We performed one interesting experiment on a group of cases with sulfathiazole. In the British army, and of course in civilian life, there are many knee-joint injuries due to the fact that one plays football of the nature of what we call soccer. So, therefore, semi-lunar cartilage lesions are very common, and the convoys would come in with fifteen which was the largest in any one day, all of which had to have cartilages removed. We thought it might be well to see what sulfathiazole would do in a joint, as far as the level was concerned. So we started in on these cases and gave them 2 grams of sulfathiazole at noon the day before, 3 o'clock in the afternoon, and then at six, and after that at four-hour intervals, giving a gram and a half until six the next morning. They go to the operating room the next morning. The urine would be taken. The blood would be taken in the operating room. We would open down to the synovial membrane of the knee and then with a needle asperate the knee joint fluid. After running thirty of these and the findings all being the same, we stopped because we found that the level of milligrams per cent in the synovial fluid of these knees was, to all intents and purposes the same as the blood level. So that the synovial fluid in a joint of this character certainly contained the drug practically the same as did the blood itself. We also found this appeared in what was called closed cavities.

There was a young soldier who had a bursa under one of the hamstrings about the size of an egg, according to his history, and which had never bothered him at his work, but which when he got into the army began to irritate him. We excised it without breaking it, giving him the sulfathiazole from the day before in the same way as we did in the knee cases. And we found that the sulfathiazole level in the fluid in this bursa was almost up to the blood itself, showing how the drug does go through the body, and how there is an interchange at all times. I believe that this seems to have some definite bearing on the treatment of joint injuries with potential infection.

COMMENT

Changes of plaster being treated by the Orr-Trueta method, and this does become absolutely necessary at times, may cause disturbance of the fractured fragments, and for this reason and as well as for the facts that certain fractures as in the shaft of the femur, for instance, cannot be held properly with plaster alone, so further fixation is needed if it can be obtained. At the American Hospital, in Britain, pin fixation, as described by Orr and Anderson, and Haynes and others was utilized for this purpose, and we believe it has a definite place in war surgery both in compound and simple fractures. I have a movie of some of these cases which I am going to show before the Section on Surgery tomorrow. With this type of fixation, that is, a pin fixation, patients are more mobile, and plasters can be changed as often as necessary, without any danger

of motion at the fracture site. In one of our badly-comminuted, compounded-infected femurs the Anderson pins was left in for six and a half months until the healing of a large soft part wound and the fracture itself had taken place. The pin holes healed up within a few days.

I was asked to come down to a meeting of the Medical Officers of the First Canadian Division who had an organization, and to give a talk on this matter. They sent up three ambulances and I took a dozen men down from our hospital, one of whom had a fractured femur that had only had the pins put in the day before. It was 45 miles away and 45 miles in Southern England, even in peace times is equivalent to twice that over here because of the winding narrow roads, etc. We took those men down there, gave a clinic on them, came back, and demonstrated very definitely how these war casualties could be evacuated and carried without producing any shock, with and only, of course, the tiredness that goes with the trip. And, in areas (and that means all of Great Britain which is subject to bombing at any time), these cases of fracture must be gotten out of the congested areas or the areas where bombing might take place and out into the hospitals in the country. And, fractured femurs can be moved without a great deal of trouble, with pin fixation.

Time does not allow me to take up any of the other subjects which are of such prime importance in war surgery, or to describe my observations on them in England, and I see that most of them are covered in your program later. Blood banks, plasma, treatment of burns, early skin grafting, periphereal nerve injuries, and other measures might all be discussed at length, and are as vital as any of the factors that I have mentioned. In closing, it should be emphasized that with basic surgical training it is not always a question in wartime of what a surgeon should do, but of how and when to do it. Only broad surgical judgment and experience can decide these factors.

25 West Fourth Street.

CENTRAL NERVOUS SYSTEM SYPHILIS

ITS TREATMENT AT THE STOCKTON STATE HOSPITAL

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Stockton

BECAUSE of the shifting of population, due to war work and men in our armed forces, there will be an increase in syphilis, and a certain number of these cases will develop central nervous system syphilis.

We believe that a report of cases treated in the Stockton State Hospital will be of interest to medical men, and will encourage them to make an early diagnosis and see that these cases are properly treated before they become hopeless. For this reason, the Department of Institutions has set aside wards where those so afflicted may come and be treated. If they are unable to come voluntarily, they can be sent by the courts to have the treatment with which they can, in some cases, be restored to health. There has been a gradual increase in the numbers of cures as new methods have been established, and as these methods are improved we hope to increase the number of those who can be returned to civil activities.

CLINICAL MATERIAL

This report includes 314 cases of central nervous system syphilis which were treated with malarial fever. Eleven patients died during the treatment or shortly after the fever was terminated; 169 were paroled or discharged as well enough to resume normal activity, and five of these were returned as unable to get along. The youngest was 13 years old and the oldest was 62. Many of the patients were disturbed, some had bed sores and seemed hopelessly in advanced stages of the disease. One hundred and eleven came voluntarily.

PROCEDURES

All of the patients showing syphilis are fluoroscoped to determine the condition of the heart and aorta. In some who showed marked syphilitic heart disease, an improvement was noted by the use of potassium iodide and bed rest.

First, three weekly doses of tryparsamide were given to find the patients' reaction to the drug, and to allow them to become used to the new surroundings. They were then given intravenous blood drawn from a patient about to have a chill, and with a large number of parasites; about two c.c. of blood was drawn into a syringe with citrate solution and injected into the patient. This was followed with 10 c.c. of glucose solution through the same needle. If no chills resulted in four weeks, the dose was repeated. The patient was allowed to have about 12 chills, more or less, depending on the physical condition of the patient. They were given Vitamin C, as well as a generous amount of well-sweetened lemonade and occasional intravenous doses of Vitamin B in glucose solution. All were given extra diet high in sugar. The intravenous glucose helps prevent convulsions as well as keeps up the strength, and we have been able to keep patients alive when they seemed unable to stand the treatment. Too frequent chills were controlled by five grains of quinine. The malaria was terminated by atabrine and quinine, as we found there might be a return of the malaria unless both were given. Three weekly doses of neo-arsphenamine were given, and then 20 doses weekly of tryparsamide, followed by four weekly doses of oily bismuth. This routine was followed until 100 doses of tryparsamide were given, and then a spinal test was taken to determine the results. The bismuth is given so that the patient does not establish a tolerance to the arsenical, as we have found bismuth to be of little help in these cases.

COMMENT

The few who developed skin reactions were cleared up by intravenous nictinic acid and the local use of sulphathiazole ointment. In some few cases, we had to discontinue the tryparsamide and resort to other arsenicals, such as mapharsen.

Many of the patients did not show much improvement for six months. Most of the cases, where there was optic nerve involvement, went on to blindness, but two cases showed marked improvement. A constant check was maintained to show any signs of beginning blindness, but we were never able to determine that tryparsamide was to blame for the damage.

We are trying to improve some of the tabes dorsalis patients by the intraspinal use of glucose and nicotinic amide, and thus far they are improving, but the experiment has not been carried on long enough to be sure of results.

Most of the cases which show cardiac disturbances following malaria react well to strychnine given twice a day, orally.

We kept as many of our patients as would stay, for four months, and seldom allowed one to go under three months. Many of them stay for the entire course of treatment.

It is impossible to maintain contact with all of the cases, but a number are employed locally and others write us telling how well they get along. Of those working locally we have examined a number, and they seem to remain well and are able to work in shipyards. The kneejerks were normal, the pupils reacted, and they were free from tremors; but we found that those who had marked speech defects were apt to have some residuals of the speech defect.

We did not follow any set routine, but endeavored to vary the method to suit the individual; and we feel that the results are in part due to our complete control of the case during treatment.

The patients were, as a rule, very coöperative as soon as they realized the gravity of the disease and the results of not continuing after-care. All of these patients react badly to alcohol, and will not be able to get along well if they use any alcoholics, even after they leave the hospital.

We were able to train our employees so that they understood the treatment, and to the faithful work, interest and pride of a deed well done by these attendants we owe much of our success.

Our superintendent, Dr. Margaret Smyth, gave us her entire coöperation, and, by her interest, enabled us to carry on the work in spite of the difficulty arising from war restrictions.

Stockton State Hospital.

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PRACTICAL ETHICS*

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IT has been said that ethics was formulated and developed by the weak to protect themselves against the strong. Perhaps it is desirable to attempt to counteract the predatory instinct which evolution has not, as yet, eliminated from most of us. The word ethics is derived from the Greek "Ethos," meaning custom, usage, character. By extension, as we use it, it means conforming to professional standards of conduct. The word practical is used in this discussion to mean "manifested in practice," as opposed to theoretical, ideal, or speculative.

We may set up various codes of ethics and memorize them, but they are valuable and useful only to the degree in which we succeed in manifesting them in our contacts and relationships. What price ethics if we accept the principles and act upon them only to a certain point or with certain groups, dispensing with them in so far as other groups are concerned.

PRACTICAL ETHICS: ITS CONNOTATION

Practical Ethics refers to the part of our codes of ethics that we actually adopt and use, because we have found it desirable and advantageous, in one way or another, to do so; because, for example, we have found that the way is made smoother; our contact with others, the public, our patients, our colleagues, is made pleasanter. In so far as we have recognized ethics to be practical it is not difficult to abide by the rules. It is otherwise as to principles that remain abstract and theoretical, or as to those parts of the Code which are, in our observation, unfortunately so generally disregarded or infringed upon. I believe, however, that the code of ethics to which we have subscribed is essentially sound in principle, and in very large measure practical. To some extent we can determine its practicability in observing the results which follow the disregard and abuse of some of its principles. This is particularly and strikingly illustrated when we consider the results which follow disregard of the principle which holds that we must not, unethically, criticize our fellow practitioners. I am sure that you will agree with me that no principle of our code of professional conduct has been, and is being so generally disregarded as this one. Why does one who is a member of a healing profession speak disparagingly of a fellow practitioner? Will we all agree that no physician can fairly and ethically criticize the work of another until, and unless, he is in possession of all of the facts of the case? Must he not have the physician's version as well as the story of the patient? Yet 90 per cent of all of our malpractice claims and suits are precipitated by the unwise comments or criticism of one physician in respect to the professional conduct of, or the results obtained by, another physician. In the

* Read in 1943, before several medical groups in Southern California.

great majority of these instances it is criticism by a succeeding doctor of his predecessor on the case. Does the one expect to expand himself at the expense of the other? What does it profit him? If the patient is intelligent, I can see no profit in it. On the other hand it seems to me that it tends to injure all concerned, the maligner, the malignee and the entire healing profession.

UNETHICAL CRITICISM: ITS RESULTS

The results indicate that unethical criticism is destructive; that medical prestige is lowered; the patient's confidence in the profession is undermined; and the reputation of the criticized physician is damaged.

The patient is encouraged, in fact may be led to bring an accusation of malpractice against the maligned and generally innocent practitioner. I say generally innocent advisedly, because 80 per cent of the malpractice claims made locally are unjustifiable; that is, 80 per cent of these claims are without merit. Thus the generally innocent defendant is further injured in reputation and prestige, in loss of time, and, all together, is subjected to a most unpleasant and harrowing experience.

HOW MANY MALPRACTICE CASES ARE BORN

Strict adherence to our ethical codes would eliminate a large proportion of the unjustifiable malpractice claims that now harass and torment us. A highly respected malpractice attorney of great experience, now deceased, used to say: "Malpractice cases are born in the offices of the succeeding physicians." The little progress we have made in discouraging condemnation of the other fellow makes it certain that if and when this observance becomes general, when this ethical principle becomes practical and functioning, rather than abstract and unapplied, the malpractice incidence will fall.

REPORT OF CASES

Case 1.—Consider the recent case involving two physicians who practice as partners on the outskirts of Los Angeles. They have an equipment to administer x-ray therapy, and employ a technician. A patient presented an eruption on one of her hands. One of the partners, Dr. A, prescribed a course of x-ray treatments. These were administered by the technician. Some weeks later the patient returned to the office. At this time Dr. A was absent from the city. The patient was sent in to Dr. B, who was seeing her for the first time. Without giving the patient an opportunity even to state her name, Dr. B exclaimed: "Good heavens, woman, someone has certainly given you a terrible x-ray burn." The punishment fitted the crime this time, Dr. B being equally liable with his partner for the negligence of their employee.

Of course, the above case presents a striking and unusual illustration of destructive criticism based on too little information. It is probably true that a criticising physician isn't often motivated by malice. He may be talking thoughtlessly, or when in an egotistically expansive mood. But the damage is usually just as great as though he were acting maliciously. It isn't necessary for destructive criticism to reach such a point as to ask the patient, "Who butchered you?" or "Didn't you know better than to go to such a man?" Just the lifting of an eyebrow has been sufficient to precipitate a malpractice action. And, too, suit has resulted from the attempt, occasionally even the unintelligent attempt, on the part of the succeeding doctor to justify himself by throwing an onus on the doctor who previously cared for the patient. Consider the following case:

* * *

Case 2.—A diagnosis was made of carcinoma of the sigmoid. Dr. A operated. Extensive envolvement was found and the patient did not stand the operation very well. A colostomy only was done. Dr. A advised the family that no more could have been done at the time without seriously endangering the patient's life, and that it was very doubtful if radical surgery would be advisable at any time. Three months later Dr. B undertook radical resection. The patient died. Dr. B said that everything would have been alright if Dr. A had performed the operation three months earlier, as he should have done, and as he, Dr. B, would have done had he had the patient at that time.

The patient's family immediately threatened Dr. A, demanding compensation. However, with the passage of time, having had opportunity to give further consideration to the facts, the family seem now to have concluded that Dr. B should be sued instead of Dr. A. It would appear that if a case exists at all, it is against Dr. B.

In the case just cited, Dr. B did not contact Dr. A or have any knowledge of the case other than that obtained from the patient. As a matter of practical ethics, should not a succeeding physician, for the benefit of the patient and for his own protection, obtain any available information from a preceding doctor? I would earnestly recommend it. If in particular circumstances it is difficult to contact the preceding doctor, or to secure his coöperation, it is not unlikely that a liaison can be set up through your Committee on Medical Defense.

THREE CONSTRUCTIVE PROCEDURES

In this connection it is suggested that utilization of the procedure outlined in the following three paragraphs would be constructive:

1. When a patient, especially one expressing dissatisfaction with treatment, progress or result, discontinues treatment while treatment is still necessary, a letter should be sent to the patient incorporating the pertinent facts, and recommending that further treatment be had. A carbon copy of the letter should be filed with the medical case record, and the facts should immediately be reported to the Committee on Medical Defense.

2. When a succeeding physician undertakes the care of a patient who has left the care of a prior physician under circumstances as set forth in paragraph 1 above, the succeeding physician should advise the Committee on Medical Defense.

3. The simple fact that Dr. A is treating or has treated patient B is not information protected by the Privileged Communications Statute.

Obviously, if no knowledge of a potentially dangerous situation comes to hand there is nothing that anyone can do to quiet the troubled waters. On the other hand when, because of information received, it becomes possible to investigate the circumstances out of which a claim is threatening to arise, the facts are obtained before they crystallize unfavorably, before a succeeding physician has committed himself to a position possibly antagonistic to the preceding physician.

COMMENT

It is surely a matter of practical, and for that matter of ideal ethics to protect a fellow practitioner. It is understood, of course, that the purpose and practice is not to defeat any legitimate claim of any patient, that the intent is not to whitewash any doctor who has ignorantly or negligently injured a patient. In seeking to be relieved of unjust accusations of malpractice, we do not seek to work an injustice upon a patient.

Many cases, the number constantly increasing, might be cited to illustrate the effectiveness of the early reporting of threatening situations. Physicians have constantly been urged to report immediately when it is learned that any patient is contemplating a malpractice claim against any doctor.

No practitioner can obtain good results in every case. No inference of negligence arises out of the fact alone that an untoward or an unexpectedly bad result follows treatment. If such were not the case every tombstone would serve as a perfect foundation for a malpractice action. But a patient, disappointed and unhappy because not cured or even improved, is inclined to blame his professional attendant. In fact, in this area, the people seem to have been educated to blame the doctor for any undesirable result. Not uncommonly a disgruntled patient makes the rounds endeavoring to find a doctor who will aid in supporting a malpractice claim. As the patient relates his story to the succeeding doctor it may truthfully appear that the preceding doctor has followed some procedure that the succeeding doctor, himself, would not have utilized. It must be borne in mind, however, that what a particular physician would or would not do is not the standard.

ON DIFFERENCES IN PROFESSIONAL OPINIONS

There are few conditions in which there is available a sole and specific remedy or procedure. There is usually a great latitude for honest difference of opinion, and it is often a matter for the exercise of the best judgment of the attending physician to decide which method he will use. He may later wish he had selected another, and in retrospect perhaps a better, method; but the physician must act without the benefit of hindsight. A physician is not required to follow a particular procedure. He is justified in his conduct of a case if the method employed is such as would be approved by even a respectable minority of his confreres in the same locality.

The succeeding doctor may be a specialist in the field or otherwise possess unusual skill and knowledge far beyond the average reputable practitioner. The standard, it is pointed out, is measured by the knowledge, skill and care of the ordinary reputable practitioner in the same general field of practice in the same community at the time in question. Practical ethics requires, as does the law, that we fulfill our duty to our patients, that we recognize and fully meet our responsibilities by undertaking to care only for those cases that are well within our capabilities; by conscientious study and investigation of the problems of each case, utilizing any and all indicated laboratory aids; by keeping abreast of the times and adopting approved methods of practice; and by acting toward every patient with the utmost good faith, recognizing that the physician-patient relationship is one of trust and confidence.

MALPRACTICE: AS A DISEASE OF THE SOCIAL BODY

Malpractice may be regarded as a sort of disease of the social body, endemic if not epidemic in distribution. The chief predisposing factor is ethical instability or deficiency. In one sense malpractice may be said to be contagious; the winning of an action by a patient invariably causes a temporary increase in the number of claims.

The intensified competition and the economic stress of the last two decades, the breakdown of the traditional general-practitioner-patient relationship, and the increase in "suit consciousness" due to the large number of personal injury actions partially explain the high malpractice incidence. Another factor which probably stimulates malpractice suits is the fact that they are difficult to defend. Several conditions are responsible for this. In the first place the physician is often unnecessarily vulnerable. The average physician is peculiarly naïve in some respects. Apparently he cannot believe that his patient, for whom he is doing his best and in whose welfare he is sincerely interested, will turn on him; thus, not anticipating the likelihood of a suit, he fails to take necessary precautions which would assure him of the best possible defense in the event of suit.

Again, as is too often the case, there is too great delay in the investigation of claims; and this, as has been pointed out, is disadvantageous to the defense. Finally, most cases are heard before juries made up of lay persons. It is a truism that no one can say what a jury will do. This is particularly true in respect to malpractice cases. Certainly lay jurors cannot be expected to understand complex medical facts. How do they arrive at a decision in these cases when two expert witnesses say that the defendant's conduct of the case did not meet the required standard, and two others say that what the defendant did was consistent with the usual and ordinary practice in the community?

PREVENTION IS THE BEST DEFENSE

Prevention is the best defense against malpractice. Making our ethics practical is an important,

if not the most important factor, in the prevention of unjustifiable malpractice claims. It is basic, of course, that the practitioner, if he is to avoid actual malpractice, must care for every patient with meticulous attention to the requirements of good practice. Bitter experience has taught us, however, that this does not ward off the unjust accusation and that no practitioner is immune. It is essential to be in a position to prove that the standard demanded by the law has been met in every case. Ideal case records are a bulwark. Obviously, the practitioner rarely has anyone who can testify in support of his contentions, but good records, office and hospital, go a long way in supporting his statements. Also the use of a consultant gives great protection. It is desirable to have a consultant see every patient who is not doing well or who is complaining or expressing dissatisfaction. When a consultant has seen the patient during the critical period, his testimony given in court has tremendous force. Practitioners would do well to give routine protective consultations, one to the other, whether or not a consultant's fee is available in a particular case. Practical ethics might well comprehend such a plan. It would not be undesirable in the interest of the patient, and it would give protection to the practitioner.

CASES IN ILLUSTRATION OF PRACTICAL ETHICS

A number of cases are cited which illustrate the value of practical ethics and the injury suffered by practitioner, patient and public, alike, when ethical principles are disregarded or abused.

REPORT OF CASES

CASE 3.—This was a case of external and internal hemorrhoids, and prolapse of the anus. The patient was operated. Following the surgery, a "whistle" tube was placed in the rectum. It consisted of a ⅜-inch rubber tube about 5½ inches long, wrapped in the middle 4 inches with vaselined gauze to a total diameter of 1 inch to 1¼ inches. The tube was not anchored. Castor oil was administered on the fourth day, but, contrary to written orders, the eliminations were not checked, and it was not known whether the tube had been passed or not.

The patient's wife was advised as to the possibility of the tube remaining in the body of the patient.

The operating physician was discharged from the case within a few days after the patient left the hospital, and another physician called in. The patient's wife stated, on the witness stand, that she told the second physician about the uncertainty in regard to the drain tube. About ten days later the patient was reoperated, in another hospital; hemorroids were removed, but the tube was not seen.

Four weeks after the second operation, the tube presented at the anus, when the patient strained at stool. It was removed next day, by the second operating physician.

The first operating physician was sued on the theory that he did not follow good practice in using the "whistle" tube, and that he was negligent in failing to remove it, and in not determining whether it remained in the body. There was no allegation of unskillfulness or of negligence in the performance of the surgery. Judgment was given in favor of the physician.

Comment.—The second physician in this case did not contact the first physician to ascertain the prior condition and what had been done; nor did he ask to see the hospital record covering the first hospitalization of the patient. It is suggested that he should have done so in the interest of the patient and that, had he done so, there might have been no suit in the case.

* * *

CASE 4.—The patient was engaged in putting asbestos covers on metal pipes, clamping the covers to the pipes by means of metal bands. He fell from a scaffold while holding one of the metal bands grasped in his clenched hand. His thumb was dislocated and, when his hand was opened, it was found that he had sustained an oblique laceration across the palmar surface of the little finger, beginning slightly above the base of the little finger upon the radial side and ending approximately at the base of the little finger on the ulnar side.

The injured hand was wrapped in some gauze, and the patient went to the office of the company's physicians.

The wound was found to be slightly irregular, with some maceration of the margins. A diagnosis was made of severance of the profundus flexor tendon. The tendon sheath was found, but the proximal end of the tendon was not, although, to permit further search, an incision of an inch to an inch and a half was made at the end of the original laceration, on the ulnar side, extending proximately along the ulnar margin of the palm. Approximately an hour was spent in the treatment, which included surgical cleansing of the parts, induction of novocaine anesthesia, debridement of the wound, making additional incision, search for tendon, and application of dressing. At the end of the period of unsuccessful search the physicians concluded that the patient should be hospitalized and so notified the compensation carrier. Upon being so instructed, the physicans sent the patient to a hospital and they, thereafter, had no part in the treatment of the patient.

At the hospital, the patient, now under the care of a second group of physicians, was put to bed, under observation. It was decided that no further incisions should be made in order to locate the profundus tendon, but that secondary tenorrhaphy would be done. A severe tendon sheath infection developed, necessitating a series of incisions to evacuate pus and produce drainage. The final result is a hand with practically no function, with the little finger amputated and with marked contracture of all of the flexor tendons.

The patient sued all of the doctors who treated him, the first group as well as the second. Conflicting testimony, more or less typical of all these cases, was presented in court. The patient testified that his hand was not even washed by the first doctors, that these doctors did not scrub their own hands, but worked upon him coming directly from another patient, that the first doctors made other and different incisions; that, while in the care of the second group of doctors, no one even looked at the hand for days, that unpadded casts were applied so tightly that the flesh fell off, that even after weeks in the hospital and after a series of operations, and after hot wet packs had been used for weeks, there was still asbestos on the hand, etc.

This case was in trial for 32 days; the jury were unable to agree upon a verdict.

INDUSTRIALLY INJURED PATIENTS

Not infrequently, an industrially-injured patient, after being treated for a time by one physician, is sent, by direction of a compensation insurance carrier, to another physician. From the malpractice angle, this practice creates a potentially dangerous situation. If the end result leaves something to wish for, and the patient is dissatisfied, he may bring suit against both the first and the second physicians who cared for him. Both physicians will be named in the action as codefendants. Every effort is then made by the plaintiff to manipulate the situation so that the two defendants become, in effect, adversaries. If successful, it is of course very satisfactory from the point of view of the plaintiff, but decidedly detrimental to one or both of the defendants.

In California and in a number of other states, an industrially-injured patient, although he has accepted a compensation award, may nevertheless have an action for malpractice against the physician who treated the injuries. The insurance company which paid the award will be entitled to reimbursement from any judgment recovered.

It is important under a set of circumstances such as those set forth in this case, that the records of all the physicians involved should be detailed and exact, and the principles of malpractice prophylaxis should be specially borne in mind.

* * *

Case 5.—An Obstetrical Case. Normal gestation; normal delivery in hospital; normal puerperium while in hospital. Home on tenth day. Immediately began to flow. Gushing hemorrhage on twelfth day. Patient returned to hospital. Blood studies were made; red cell count, hemoglobin estimation, typing, etc. The patient was transfused and curreted with dull curret. No placental tissue found. Packed.

At this point the first physician was discharged. The succeeding physician moved the patient to another hospital. According to the hospital chart of the second hospital, a piece of placenta about 7 cm. across was found on the packing when it was removed. Nevertheless, the second physician thereupon curreted the patient. Following this, the patient ran a high spiking temperature and was very ill for a number of days. Treated with sulfa drugs and repeated transfusions. The first physician was sued on the theory that he had failed to remove all of the placenta. The second physician appeared as a medical expert witness for the plaintiff. The jury brought in a verdict in favor of the defendant physician.

Comment.—The succeeding physician took over this patient without contacting the first physician and, apparently motivated by the need to justify himself, declared that he took charge because action was necessary to save the patient's life. The bill he eventually rendered was, considering all the circumstances, excessively large. It was fortunate that the statute of limitations as applied to the succeeding physician had already run before the case against the first physician came to trial. In the opinion of some of the physicians who studied the case, if the patient had a justifiable complaint against anyone, it was against the succeeding physician.

The necessity of eliminating the unethical and dishonest practitioner, in order to safeguard the profession and the public, is obvious.

* * *

Case 6.—This was a complex and most unusual case. A young woman, married about two months, presented herself with a history of not having menstruated since marriage; of having been nauseated for about one week, and of having had cramping pain in the lower abdomen for a few days. The onset of the pain was accompanied by spotting. A-Z was positive. Temperature normal, blood picture normal, except leucocytosis (16000). Examination disclosed uterus soft and enlarged to twice normal size. Marked tenderness to right. The examining physician believed that he made out a soft mass in the region of the right ovary and a smaller mass immediately adjacent to the uterus in the region of the right tube. The latter mass was exceedingly tender. A diagnosis was made of (1) probable cyst of the ovary, (2) possible tubal pregnancy, and (3) possible subacute appendicitis. Immediate operation was recommended.

At operation, according to the hospital record and the testimony of the operating surgeon and his assistant, there was found (1) cyst of right ovary, size of egg, (2) subacute appendicitis, and (3) a swelling of the right horn of the uterus, extending along the right fallopian tube for approximately 1½ inches. The swelling in the tube was about equal in size to the terminal phalanx of the thumb, but it decreased in size from uterus outward. It was testified that the operator picked the tube up in his fingers to examine it and that during palpation, it was seen and felt that some mass slipped into the uterus. Thereupon, the surgeon went in from below, while the abdomen was still open, and through the cervix removed a pregnancy sac intact.

Following this, the cyst and the appendix were removed. The operating surgeon testified that the postoperative progress was normal, other than that a low-grade infection, which developed in the wound, drained for several weeks. The patient testified that she thereafter menstruated normally for about six months, but that she had nausea, dragging pain in lower abdomen, some vaginal discharge, and that she lost weight. At the end of six months' period, she consulted another physician to whom she gave this history. He testified that, while his findings were consistent with endometritis, the uterus was normal in size. The patient did not return to him, but, two months later, consulted another physician, who, for purpose of identification, may be designated as Dr. X. Dr. X found the uterus soft and three times normal size; there was marked tenderness in the right adnexal region and the patient was flowing heavily and passing large clots. He made a diagnosis of endometriosis (endometritis?). A consultant, who was called in, confirmed the diagnosis. It was considered to be due to the original surgery, now interpreted as having been an incomplete abortion, (of what had been a normal intrauterine pregnancy). The patient was treated with sulfa drugs, diathermy and rest. The bleeding stopped and there was some improvement in the general condition. It is exceedingly interesting to note that the patient must have been pregnant during this time in view of later developments. It was observed that the uterus, while it seemed to decrease somewhat in size in the beginning of this course of treatment, soon began to enlarge. An A-Z was positive. The patient was in hospital for a brief period when she was approximately five months pregnant, apparently threatening to miscarry. When eight months pregnant, she went into violent labor. A caesarian section was performed on the diagnosis of threatened rupture of a uterine scar. The operative record states that there was

a "thin scar in the lower uterine segment," but the surgeon who performed the caesarian section testified that he had no independent recollection of a scar on the uterus. This operator did not contact the original operating physician or ask to see the original hospital records —and, in passing, it may be remarked that neither did Dr. X. Following the caesarian the patient made a good recovery, but the baby died. Dr. X and other physicians were now unable to find anything of an organic nature wrong with the patient. The tubes were found to be patent. The patient, however, remained underweight and complained of nausea, and pain and tenderness in the pelvis.

The first operating surgeon was sued. The charges were complex and multitudinous, but as finally developed during the trial, they were basically (1) lack of skill and care in diagnosis, (2) improper and unskilled surgery, and (3) unskillful and insufficient after-care. It was pictured to the jury, largely by Dr. X and the surgeon who performed the caesarian section, that the patient did not have the tubal pregnancy as described, that the products of conception could not have been displaced into the uterus, that had the patient presented a tubal pregnancy, something else should have been done, etc. Moreover, great stress was laid upon the presence of the scar in the lower uterine segment which, it was claimed, was due to the unskillful use of a curret in the hands of the first operating physician. The jury brought in a verdict in favor of the patient.

Comment.—Dr. X was responsible for the bringing of this action. There is no doubt but that he believed that this was a meritorious case. However, he erroneously believed that "sticking" the defendant in a civil malpractice action would result in eliminating him from the professional ranks. Such a result is not accomplished in this way. The local malpractice picture has been adversely affected, as the result of the vindictive prosecution of this case regardless of how idealistic Dr. X's motives may have been. The plaintiff and her attorney were undoubtedly influenced by Dr. X's attitude. This was manifested in their refusal to discuss settlement on a basis which the defendant could regard as reasonable. It may be stated that the amount awarded by the jury was less than the plaintiff might have had in an amicable settlement. Who, then, profited? A more constructive result might have been had for the patient, the public and the profession.

' ' '

Case 7.—This was a wrongful death action brought by the decedent's heirs, his widow and son, against the defendant physician. A tonsillectomy was performed upon a man forty-odd years of age. Three days later the patient died. It was alleged that, at the time the operation was performed, the patient was suffering with Ludwig's angina and also, that the patient was an alcoholic, to the physician's knowledge, and should not have been subjected to surgery. The jury's verdict was in favor of the defendant physician.

Comment.—Ordinarily, in a case of this sort, as in a malpractice action, it must be established by medical expert testimony that the defendant physician was negligent and that his negligence was the proximate cause of the injury complained of (of the death of the patient in this case). In the absence of medical expert testimony, the plaintiff has failed to make a case and a nonsuit should be granted. In this case the plaintiff called four physicians to the stand, but would not have made a case for the jury except for the testimony of one of them. This gentleman was willing and anxious to condemn the defendant's conduct. That he was receiving a fee for testifying was not denied, and he also admitted that in the recent past he had had his license to practice suspended upon the charge of drug addiction.

Another of the plaintiff's medical witnesses who, unknown to the defendant, had been treating the decedent, testified that he had examined the decedent's throat upon the very day of the operation, that there was no infection, and that he was, himself, preparing the patient for tonsillectomy. Needless to say this testimony was a surprise and a shock to the plaintiff's attorney.

What targets medical men are for unjust accusations of this sort! It is as unfortunate as it is certain that the public interest suffers as a result.

' ' '

Case 8.—Another obstetrical case. A border line contracted pelvis. The patient's average weight was about 86 pounds. It was considered that a caesarian section would probably be necessary. X-rays were taken to determine the question of disproportion. It was decided to give the patient a test of labor. She delivered a 6 lb., 2 oz. child, which was normal and breathed spontaneously. Low forceps were used and a double episiotomy was done. The perineal incisions became infected, and the scars remained tender, resulting in dyspareunia. The obstetrician was sued. The defendant's motion for a nonsuit was granted.

Comment.—A double episiotomy is unusual. The result in this case could be considered excellent. It is believed that had a consultant been called in there would have been no suit. The occurrence of a perineal infection caused the patient to lose confidence in her physician and, unfortunately, the physician next called in did nothing to restore it. On the contrary, he apparently suggested to the patient that she had been unfortunate in her first choice of physicians. but was finally in good hands. And, as coincidentally so regularly appears in such circumstances, the succeeding physician's bill was large.

' ' '

Case 9.—A boy of 13 fell on the school grounds, injuring his right elbow. He was immediately taken to the defendant physician who diagnosed the injury as a backward dislocation of both bones of the forearm. No x-ray was taken at that time. Under evipal anesthesia, the arm was manipulated, and, according to the attending physician, the dislocation was reduced. The arm was put in the Jones position, held by adhesive tape. There was marked swelling about the elbow and some blebs formed and broke. However, the physician did not see the patient, according to plaintiff's testimony, until three days later, although the arm was let down to a right angle position across the chest on the day following the injury. This was done following the instructions of the doctor which were given over the telephone.

X-rays, made three days after the injury, disclosed that the joint was in good position, but that there was a frac-

ture of the median epicondyle with the fragment displaced downward to the level of the elbow joint, and a chip fracture of the lateral epicondyle. At this time there was numbness of the little and the medial half of the ring finger, and of the palm in the hypothenar area, and the little and ring fingers were drawn up in flexion to a ninety degree angle. At this time a moulded plaster splint was applied to the posterior aspect of the arm and forearm, holding the elbow at a right angle. Under the doctor's instructions, again over the telephone, the cast was removed by the parents of the patient about three weeks later, and thereafter the arm was carried in a sling. The doctor also gave instructions that the parts should be massaged daily, and that the patient should carry a "bucket of rocks" for some minutes three times daily. About three weeks later, evipal was again administered to the patient and the physician attempted to increase the motion in the joint by some forceful manipulation. This was unsuccessful.

One week later, the patient was placed in the charge of other physicians. X-rays taken at this time showed the fractures as disclosed in the only x-rays which had been made by the first attending physician, plus fairly marked myositis ossificans blocking flexion beyond 65° and extension beyond about 125°. Ulnar palsy was also diagnosed. At surgery, the displaced median epicondyle was removed and the ulnar nerve dissected free from scar tissue and transplanted anteriorly. The ulnar paralysis disappeared entirely during the next few weeks.

At the time of the trial of the malpractice action brought against the first attending physician, the limitation in motion remained about as indicated above. The experts generally agreed that further improvement could reasonably be expected to result from additional surgery. The jury brought in a verdict in favor of the plaintiff.

Comment.—This was a case in which the medico-legal advisers recommended settlement. The plaintiff had expressed a willingness to accept an amount which was only half as large as the judgment eventually obtained. Had such a settlement been made there would also, of course, have been a great saving in the way of legal expense.

While the entire course of care of the attending physician in this case might be criticised, the following four points should, from the angle of malpractice prophylaxis, be emphasized: (1) the importance of taking initial x-rays and sufficient x-rays thereafter; (2) the legal duty of giving sufficient care and attention, (it was claimed that this patient was seen only five times); (3) the desirability of having consultation protective both to the patient and the physician; and (4) the necessity, in the selection of patients, to accept only those that the physician is well qualified to care for.

* * *

Case 10.—Intestinal obstruction caused by a constricting band developed in a woman at the time she was about four and one-half months pregnant. This was the patient's second pregnancy; three years before there had been an early abortion (curettage). Five years before, an appendectomy and a right oöphorectomy had been done. The current pregnancy was uneventful for four and a half months. Then, according to the history, following a meal of Mexican beans, the patient was nauseated and had abdominal cramps. She was hospitalized. There was considerable vomiting and some abdominal distention. The patient was treated conservatively. In the first twenty-four hours there was no bowel movement and the distention increased. During the next twenty-four hours there were five bowel movements and the distention markedly decreased. The patient was then allowed to go home. (The financial status of the family was a factor.)

The next evening, not being able immediately to reach the attending physician, and there having been a recurrence of symptoms, another physician was called in. (The first attending physician never saw the patient thereafter.) The patient was placed in another hospital, where she was given conservative treatment. After about twelve hours, because it was believed that surgery might be necessary, the patient was removed to a public hospital where, twenty-four hours later, an operation was performed. A constricting band of adhesions was found about the lower ileum. This was severed and an ileostomy done. The patient recovered, after a rather stormy convalescence. (The patient miscarried shortly after the operation.)

The first attending physician was sued on the theories: (1) that he had failed to use proper methods in making diagnosis, and for failure to diagnose the case as intestinal obstruction; (2) that he had failed to properly treat the patient.

The first attending physician's diagnosis, as disclosed by the hospital chart, was: (1) toxemia of pregnancy; (2) enteritis, acute; and (3) partial intestinal obstruction (?). Consultation was had. The consultant concurred in the diagnosis and approved the treatment. He also agreed that, in the circumstances, the patient might be allowed to go home, to return if necessary.

After fourteen days of trial the jury returned a unanimous verdict in favor of the defendant.

Comment.—The first succeeding physician in this case had been in practice only eleven months. His harsh and unjust criticism of his predecessor precipitated the malpractice claim. He did not contact the first physician to ascertain, at first hand, what the problem was or what had been done. He made a diagnosis of acute intestinal obstruction, complete, but nevertheless kept the patient in hospital for more than twelve hours while efforts were being made to effect necessary financial arrangements.

This case illustrates again that while a physician may be unjustly assailed, he can be in a position so that it is very unlikely that the plaintiff can prevail. In this case the defendant not only had taken good care of his patient but his records, office and hospital, were splendid and served to establish his defense. Furthermore he had had consultation at the critical moment.

* * *

These cases help to emphasize the whole point of this discussion, namely: that it is desirable to make our ethics practical for the sake of the patient, for the sake of our fellow practitioners, and for our own protection and satisfaction.

6777 Hollywood Boulevard.

We now demand to be personally conducted through life, all risks to be taken by someone else.

—Dean W. R. Inge. (Marchant, *Wit and Wisdom of Dean Inge.* No. 109.)

CLINICAL NOTES AND CASE REPORTS

SULFADIAZINE ANURIA DUE TO MECHANICAL BLOCKAGE OF THE URETERS BY CRYSTALLINE DEPOSITS

REPORT OF A CASE

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SULFADIAZINE, as compared to the other sulfonamide drugs, was proclaimed because of its reduced toxicity and fewer side reactions—particularly those involving the kidney. Some of the first reports were very favorable; but Lehr and Antopol,[2] who experimented with massive intraperitoneal doses, discovered accumulated acetylsulfadiazine crystals in the renal tubules as early as 15 minutes after injection. Almost simultaneously sulfadiazine urolithiasis in mice was recorded,[1] followed in rapid succession by clinical reports of renal damage. A review of the literature for 1942 reveals 15 published cases of sulfadiazine anuria, including five deaths.

REPORT OF CASE

CASE (180007).—J. K. S., aged 51, seen in consultation with Dr. Friedrich Gruenberg for upper abdominal and lumbar pain and hematuria. Patient had received a total of 15 gm. of sulfadiazine in treatment of acute bronchitis. Examination revealed abdominal distention, bilateral renal enlargement and tenderness, nausea and vomiting. Anuria developed, despite large doses of sodium bicarbonate and vigorous diuresis. Cystoscopy showed advanced stricture formation in the lower portion of both ureters, which were mechanically blocked by an accumulation of crystals at this level. Relief was obtained by ureteral catheterization and pelvic lavage, with 2.5 per cent sodium bicarbonate solution and rivanol (1:4000). Retention catheters were left in place for 24 hours, and fluids and alkalization continued. Nonhemolytic streptococcus was recovered from both kidneys. Patient left the hospital four days later, and no apparent permanent renal damage has been observed on subsequent examinations.

Pathological Considerations.—Two types of sulfadiazine anuria are now recognized: (1) *mechanical*, caused by blockage of the upper or lower urinary tract with crystalline deposits, and (2) *chemical*, caused by acute toxic degenerative nephrotic lesions due to calcifying necrosis. Crystalluria commonly accompanies intensive sulfadiazine therapy as a result of the drug's ready absorption by the intestinal tract, accumulation in the blood and slow elimination by the kidneys. It occurs more often in the acid medium, and is favored by stasis, infection, obstructions of the upper or lower urinary tract and a second course of therapy. In most cases, the crystals pass through the urinary tract with no damaging effects, but they may coalesce and prevent outflow of urine by mechanical blockage. Anuria, caused by acute toxic degenerative nephritis, resembles the urinary suppression of bichloride of mercury poisoning, and is associated with the toxic effect of the relatively insoluble acetyl crystals packed in the renal tubules. No evidence of permanent renal damage has been reported in patients relieved of sulfadiazine anuria.

Prophylaxis.—It is well to avoid the use of sulfadiazine in the presence of nephritis and stasis of the genito-urinary organs. Constant surveillance of the patient under therapy, and prompt recognition of signs of impending renal damage, are vital to the prevention of anuria. Microscopic hematuria may be controlled by reducing the dosage to a maximum of 4 gm. a day. Diuresis, exclusive of mercurial compounds, should provide a daily urine output of 1200 to 1500 c.c., and alkalization should sustain a pH above 7.5. Three gm. a day are sufficient to control most genito-urinary infections, and maintenance of the blood level below 8 mg. per 100 c.c. should preclude the development of anuria.

Treatment.—Microscopic hematuria, oliguria, azotemia and renal tenderness, accompanied by flatulence, nausea and vomiting, are indications for immediate withdrawal of the drug. Usually renal tenderness is elicited in the classical lumbar region; but in some cases it is encountered in the abdomen on account of congenital or acquired low position of the kidney. In the presence of anuria, alkalis and fluids should be forced and glucose given intravenously. Failure of these measures should be followed by ureteral catheterization and lavage with 2.5 per cent sodium bicarbonate and warm saline solution, or nephrostomy drainage if it is impossible to pass the catheters. Twenty-four hour ureteral catheters should be left in place, and the result checked by retrograde pyelography.

COMMENT

Sulfadiazine anuria occurred seven days after administration of 15 gm. of sulfadiazine for acute bronchitis. We believe that bilateral ureteral strictures were largely responsible for the aggregation of crystals at this level, inhibiting the outflow of urine, although the possible rôle played by nonhemolytic streptococcus should not be overlooked.

SUMMARY

1. The administration of sulfadiazine is accompanied by few side reactions; yet serious kidney complications, including anuria and death, ensue with relative frequency. The prolonged, comparatively nontoxic effect of the drug on the gastrointestinal tract is no criterion for determining the absence of renal damage.

2. Two types of sulfadiazine anuria are encountered: (a) mechanical, due to blockage of the upper or lower urinary tract with crystalline deposits, and (b) chemical, due to acute toxic degenerative nephritis caused by calcifying necrosis.

3. Obstructive lesions of the upper and lower urinary tracts favor the accumulation of crystalline deposits. Stasis, infection, acid urine and a second course of therapy are further influential factors.

4. The danger signals of impending anuria are hematuria, oliguria, azotemia and kidney tenderness, accompanied by flatulence, nausea and vomiting.

5. Prophylactic treatment consists in reducing the dosage of the drug to a maximum of 4 gm. a day, maintaining the blood level below 8 mg. per 100 c.c., forcing fluids to a daily urine output of 1200 to 1500 c.c. and alkalization to a sustained pH of 7.5.

6. In the presence of anuria, the drug should be discontinued, and ureteral catheterization and

pelvic lavage, or in some cases nephrostomy drainage, carried out.

7. No apparent permanent renal damage has been observed in patients relieved of sulfadiazine anuria.

8. A case of mechanical sulfadiazine anuria is reported, occurring seven days after administration of 15 gm. for acute bronchitis in a patient presenting bilateral ureteral stricture, relieved by ureteral catheterization and pelvic lavage.

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UNDULANT FEVER*

REPORT OF AN UNUSUAL CASE

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AND
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THE fact that undulant fever may present itself in the apparent guise of many other diseases has been repeatedly stated, but may not be realized by all of us as clearly as it should be. A recent Los Angeles County case may serve to emphasize this thought.

REPORT OF CASE

The patient, a male of 21 years, was hospitalized on January 20, 1943. His chief complaints were: Fever, chills, anorexia, cough at night, stiff neck, headache, ringing in the ears, dizziness, sweating, and weakness—several of these symptoms being of about one month's duration. Five days before hospitalization he became so weak that he had to stay in bed.

Twice during the first day of hospitalization his fever reached 104° F. It was noticed that he had hot sweats. Both optic discs showed evidence of intracranial pressure. His hearing was markedly impaired on both sides. His liver and spleen were both palpable. There were many slightly enlarged cervical nodes and firm, nontender inguinal nodes. There was no abdominal tenderness.

Tentative diagnoses: Expanding lesion around the left cerebellopontine angle; tuberculosis; Hodgkin's disease; leukemia.

On the second day of hospitalization, an agglutination test for typhoid bacilli was reported strongly positive, titer 1:2560; and a tentative diagnosis of typhoid fever was made. Blood, stool and urine cultures for typhoid organisms, however, proved negative, while a Brucella agglutination test was reported positive, titer 1:400. In view of all these facts, and especially because the patient did not seem nearly as "sick" as his fever and other symptoms might warrant, the health department epidemiologist expressed his suspicion that what ailed the patient was undulant fever.

Not long afterward, two blood cultures were reported positive for Brucella suis, confirming the epidemiologist's suspicion. As the disease progressed, the Brucella agglutination titer rose to 1:1600, while the typhoid agglutination titer finally fell to 1:640.

This patient did very well on enough sulfanilamide to keep the drug level in his blood between 10.0 and 17.6 milligrams per cent for about three weeks, after which the dose was reduced to half a gram every 6 hours.

COMMENT

The number and variety of tentative diagnoses in this case were remarkable. The most puzzling factor was the early positive agglutination test for typhoid in very high titer. The patient denied ever having had typhoid fever or ever having been vaccinated against that disease. It is, of course, possible that he had had an unrecognized case of typhoid fever fairly recently.

808 North Spring Street.

* From the Health Department of the County of Los Angeles. Contributed by the Acting County Health Officer and the Epidemiologist.

ORBELI AND WAR

Charles L. Rubenstein, M. D.
San Francisco

SAN FRANCISCO'S leaders of medicine and science well remember the famous Russian scientist, Dr. L. A. Orbeli, one of the most distinguished physiologists of our time.

It was he who inaugurated, in 1929, the now well-established Morris Hertzstein Lectures with a revealing discourse on "Influence of Sympathetic Nervous System on the Activity of Skeletal Muscles, of Sensory Receptors, and of the Central Nervous System."

Professor Orbeli has gained an international reputation through his discoveries. A pupil of Pavlov, Barcroft, Langley, he underwent unusual disciplinary training in experimental physiology. He received early training in the Pavlov laboratories at a time when Professor Pavlov's experimental work on digestion was reaching its final stages. During this same period Pavlov prepared his address for the International Congress of Physiologists, held in Madrid, in 1903, disclosing to the world for the first time the phenomenon of conditioned reflexes.

Soon after the Madrid Congress, Orbeli worked closer with Pavlov in numerous experiments leading into new fields. Notable were experiments in the physiology of the central nervous system, a domain in which Russian scientists made the earliest discoveries. In 1908, Orbeli was sent to England to study with the famous English physiologist, Dr. Langley, who saw in him a man of unlimited capacity for research.

Orbeli was mainly interested in the vegetative nervous system, and it was in Langley's laboratories that he completed his classical investigation of the fibers of the sympathetic system in amphibia. Orbeli was also associated with Barcroft at the time when the investigation of hemoglobin, as an oxygen carrier, brought the latter fame.

Although upon his return to his native Russia

his association with Pavlov became even more collaborative, his main interest lay in the study of the vegetative nervous system. When investigation first began in this line, it was believed that the sympathetic nervous system supplied the internal organs, and did not have any relation to voluntary muscles. Orbeli proved this theory was false.

To verify this, the following experiment has been demonstrated: When a motor nerve in a muscle is stimulated to a point of complete fatigue of the muscle, the latter will reëstablish its function and capacity for work for a considerable length of time by further stimulation of the sympathetic nerve.

Orbeli's results are of great value from the clinical point of view, as they explain the phenomena of a series of morbid conditions, thereby opening new avenues for proper therapeutic intervention.

Another important field in which Orbeli concentrated his attention was that of the physiology of the sense organs—sleep, experimental neuroses. Piecing together the accumulated evidence that science already offered, and new facts discovered in work with his pupils, Orbeli constructed the principles of interrelation of the organs, their harmonious coöperation and their mutual effect upon each other.

In recent years Orbeli focused his attention on studies of the function of the cerebellum, the higher center of the sympathetic system and the mechanism of regulating the higher nervous function and its evolution. He has always incorporated the principles of Darwinism in his work, trying to grasp the various physiological functions in an evolutionary manner, while also striving to bring them to a methodical use in working out new problems and in analyzing facts already established by him and his pupils.

Orbeli ranks as one of the naturalists who considers the higher organisms from the point of view of their historical relation with the rest of living organisms. It is to be noted that he does this by taking into account physical and chemical laws which present one of the principles of biological processes. Very critical of his own work, as well as that of others, Orbeli has assembled the results of his investigation in a great Russian scientific institution which today provides a most attractive center for research for all scientific workers of Russia, as well as for the entire world.

This institution, as well as the many other great centers in Russia, occupies an important place in world science. The present war has naturally disrupted medical research, inasmuch as scientists are now primarily engaged in solving the immediate pressing problems of the battle front.

The old adage, "In time of Peace, prepare for War," was never put to better use literally, than with the Orbeli Institute. The medical profession in the U.S.S.R. did not idle away the years of peace before the world storm, but kept striving for the betterment of the race through the medium of research work.

All discoveries made there which proved to be of any benefit are now applied in actual practice. Safeguarding and maintaining the health of Russia's fighting forces through preventative measures and efficacious treatment of the disabled—these are the immediate and all absorbing problems of the Orbeli Institute, as well as of all medical centers. The scientist, the research worker and the government strive today to find new safeguards for their fighting men against infection; they are working out new methods of treatment for the rapid healing of wounds, prevention and treatment of frost-bite, and furthering research in the treatment of nerve and brain impairment. All this, while the struggle for a free world goes on!

Apropos of the spirit which dominates the Orbeli Institute is the classic phrase of the Russian scientist, Alexander Frumkin:

"I consider that in wartime theory must be subordinated to the interest of national defense—all the more since the fate of science in general is at stake."

450 Sutter.

Neuropsychiatric Hospital Dedicated in San Francisco*

Ceremonies for the official opening of the Langley Porter Clinic were held on February 13, 1943. The program was as follows:

The Langley Porter Clinic is a neuropsychiatric hospital with 100 beds and an out-patient department. It was built on land which was a part of the University of California Medical School campus and which was donated by the University of California to the State Department of Institutions. The hospital consists of four psychiatric wards for adults, one psychiatric ward for children, and one neurosurgical ward. It is equipped with operating room, x-ray, and all the usual laboratory facilities of a hospital, including an elaborate setup for electroencephalography. The University of California has exclusive use of the hospital for teaching and research purposes, and exercises clinical supervision over the patients. The teaching of psychiatry by the University of California Medical School will be carried out mainly at the Langley Porter Clinic.

The Out-patient Department is prepared to receive patients and one ward for adult psychiatric male patients has been opened. As soon as sufficient nursing personnel can be obtained, additional wards will be opened. All admissions are voluntary. The tentative rates for house care are $6.00 per day and $2.00 for Out-patient Department visits. Patients who cannot afford to pay this amount will pay only as much as they can afford. If a patient cannot afford to pay anything, there will be no charge for the service. The number of patients that can be seen in the Out-patient Department is restricted and patients are seen only on an appointment basis. It is requested that any physician wishing to refer a patient should first contact the Social Service Department of the Langley Porter Clinic, who will discuss whether or not the patient is suitable for study and treatment, and who will make an appointment for the patient's examination if patient is considered suitable. The same rule applies for admission of house cases. At present the number of patients that can be admitted to the house is extremely limited and only males can be received.

* See also, pages 216 and 245.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

WILLIAM R. MOLONY, SR., M.D.....President
KARL L. SCHAUPP, M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D..Secretary-Treasurer and Editor
JOHN HUNTON.....Executive Secretary

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H. R. Hathaway, San Francisco.

Dermatology and Syphilology:
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John E. Kirkpatrick, Shasta Dam
John D. Giiiis, Los Angeles

Plastic Surgery:
George W. Pierce, San Francisco
William S. Kiskadden, Los Angeles

Neuropsychiatry:
John B. Doyie, Los Angeles
Oiga Bridgman, San Francisco

Obstetrics and Gynecology:
Erie Henriksen, Los Angeles
Daniel G. Morton, San Francisco

Pediatrics:
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Wiiiiam W. Belford, San Diego

Pathology and Bacteriology:
Alvin J. Cox, San Francisco
R. J. Pickard, San Diego

Radiology:
R. R. Newell, San Francisco
Henry J. Uiimann, Santa Barbara

Urology:
Lewis Micheison, San Francisco
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Pharmacology:
M. L. Tainter, San Francisco.
Clinton H. Thienes, Los Angeles

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Three Hundred Sixth (306th) Meeting of the Council of the California Medical Association

The meeting was called to order in Conference Room No. 4 of the Hotel Biltmore, in Los Angeles, on Sunday, February 28, 1943.

1. **Roll Call:**

Councilors present: Chairman Philip K. Gilman, and Councilors William R. Molony, Sr., Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, Frank A. MacDonald, Calvert L. Emmons, John W. Cline, John W. Green, Edwin L. Bruck, Donald Cass, and George H. Kress, Association Secretary-Treasurer.

Councilors absent: Frank R. Makinson (illness); Karl L. Schaupp (emergency-obstetrics).

Present by invitation: E. Vincent Askey, Vice-Speaker; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation; Edward M. Pallette, State Procurement and Assignment Service; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; Howard Hassard, Associate; and Ben Read, Secretary of Public Health League.

2. **Minutes:**

Minutes of the following meetings of the Council and the Executive Committee were submitted: and

(a) Minutes of 305th Council meeting, held on September 13, 1942, were approved. (Abstract was printed in C. & W. M., October, 1942, on pages 245-248.)

(b) Minutes of 179th Executive Committee Meeting, held on December 6-13, 1942, were approved. (Abstract was printed in C. & W. M., January, 1943, on pages 21-23.)

(c) Minutes of the 180th Council meeting, held on February 7, 1943, were approved, except that Councilors Goin and MacDonald wished their votes recorded as not voting in favor of the action taken under Item 12 concerning a proposed survey of medical service and hospitalization plans. (Abstract was printed in C. & W. M., March, 1943, on page 129.)

3. **Membership:**

(a) A report of membership was submitted and placed on file. Total number of active members whose dues for 1943 have been paid through component county societies is 3,517, but this includes a total of 552 members who have been reported as being in military service. (Some before, others since January 1, 1943.) Total new members included in above is 77. (Year 1942 closed with a total of 7,123 members. That total included 1,482 members who are in military service.)

(b) A list of three members whose 1942 dues have been paid subsequent to April 1, 1942, was submitted, the membership of such members having automatically lapsed on April 1, 1942. On motion duly made and seconded, their active membership for the year 1942, was reëstablished.

(Ed. Note.—For other membership notations, see minutes of 180th meeting of the C.M.A. Executive Com-

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

mittee which appeared in March, 1943, issue of C. & W. M., under Item 3, on page 128.)

(c) Upon motion duly made and seconded, it was voted that Retired Membership be granted to five members whose applications had been received in duly accredited form from their respective component county societies:

Harvey J. Forbes—Los Angeles County
J. Rollin French—Los Angeles County
Felix E. Ashcroft—San Diego County
Myrtle S. Lockwood—San Diego County
A. M. Smith—Alameda County

(c) Concerning exemption from State Association dues for U. S. Public Health Service Officers on active duty, Legal Counsel Peart reported that no such exemption could be made without an amendment to the Association's Constitution. Mode of procedure would be to present such an amendment to the House of Delegates at the next Annual Session, on May 2, 1943.

4. Financial:

(a) Executive Secretary Hunton made financial reports as follows:

Report of finances as of February 20, 1943; and report of income and expenditures for January, 1943. Same were received and placed on file.

(b) Councilor Anderson, Chairman of the Physicians' Benevolence Committee, gave a report concerning current needs, making mention of the amount of money that the Los Angeles County Medical Association has independently allocated during the past year. On motion by Anderson, seconded by Molony, it was voted that, in the budget for the calendar year 1944, the sum of $5,000.00 be allocated to the Physicians' Benevolence Fund, the same being subject to the stipulations previously laid down for expenditures from that fund.

(c) Report was made by Executive Secretary Hunton concerning needs of the Procurement and Assignment Service Committee of the California Medical Association, same being due in good part to delays in securing federal moneys for necessary supplies. It was voted that the sum of $2,500.00 be placed in the budget of 1943, to be available to the C.M.A. Committee on Procurement and Assignment as needs may arise.

(d) The budget for the calendar year 1944, as drafted by the Auditing Committee and approved by the Executive Committee, to which had been added the item concerning the Physicians' Benevolence Fund, was presented, and upon motion duly made and seconded, this was adopted.

5. Selective Service: Appointment of Local Board Members:

A letter, dated February 15, 1943, from the Honorable Earl Warren, Governor of California, was presented by Secretary Kress. In the letter, Governor Warren informed the California Medical Association that he was "asking the various county medical societies to shoulder the responsibility of making recommendations for the appointment of examining physicians serving with Selective Service Local Boards." The letter will appear in the April issue of C. & W. M., in the Department of the Committee on Participation of the Medical Profession in the War Effort. Council Chairman Gilman was authorized to express to Governor Warren the appreciation of the Council for his coöperation.

6. C.M.A. Committee on Public Policy and Legislation:

A report, concerning legislation which has been submitted to the 55th California Legislature, now in session, was made by Dwight H. Murray of Napa, Chairman of the Committee. Mr. Ben Read, Secretary of the California Public Health League, was also invited to speak concerning the proposed bills.

Proposed laws relating to the public health and to the Medical Practice Act were separately considered, and advices given to the Committee on Public Policy and Legislation in regard thereto.

7. Procurement and Assignment Service:

Edward M. Pallette, M. D., Chairman of the Procurement and Assignment Service for the fourteen southern counties of California, who was called on to discuss the present status of the work, outlined problems in connection with areas from which reports had been received concerning a presumable lack of physicians.

Special mention was made of a condition which had arisen in Blythe, in Southern California, and the steps taken to overcome what might have been a distressing situation.

The policy of the U. S. Public Health Service, in being available for aid when called upon, was discussed.

Concerning the age-ceiling applying to physicians construed to be available for the Armed Forces, Dr. Pallette stated that the age of 45, rather than that of 38, would apply to members of the medical profession. Should condition make it necessary for the Government to secure a larger number of physicians, the above age-limit may become operative. As a result, physicians who had been declared available and who have not applied for commissions, may find themselves entering service as private soldiers.

Concerning the unfilled quota for California, Dr. Pallette stated he felt the original estimate by governmental authorities had not taken into adequate consideration the large number of retired physicians in California, who are on the roster as licentiates. However, there was nothing that could be done in regard to this, other than to record the fact.

Mention was made of the extent to which rationing of tires, gas, etc., had made it increasingly difficult for physicians located in sparsely populated areas, to carry on their work. For instance, in the Randsburg region, a physician in his private practice formerly used airplanes, but now can only rely on his auto for service in his territory. To do his work, therefore, he is not infrequently obliged to violate the 35 mile per hour speed limit.

The existing arrangements concerning the Medical Procurement Officers for Army and Navy, and their duties, were discussed. (Ed. Note.—The addresses of the various officers are given in every issue of California and Western Medicine, in the footnote attached to the department of the Committee on Participation of the Medical Profession in the War Effort.)

Problems relating to the hospital units, which had been brought into being through the work of civilian defense, were also discussed. Mention was made that students of osteopathy are being deferred, although they are not receiving commissions as medical officers in active service.

General discussion followed.

8. State Boards:

Informal report was made by Council Chairman Gilman regarding recent appointments and prospective vacancies on the Board of Medical Examiners and the State Board of Public Health. The report was received and placed on file.

9. California Physicians' Service:

An overall report, presented by the California Physicians' Service, under date of February 26, 1943, and signed by A. E. Larsen, M. D., Secretary, was read.

Dr. Askey, a Trustee of California Physicians' Service, explained to the Council that Mr. Ralph R. Nelson, a well-known actuary, had been employed long since as actuary for California Physicians' Service and that Mr.

Nelson was in touch and counseling with the officers of California Physicians' Service and would report as soon as he had the necessary data on which to base a report.

10. Proposed Survey of California Medical Service and Hospitalization Organizations:

Council Chairman Gilman referred to the action taken by the Executive Committee at its 180th meeting, held on February 7, 1943 (see March C. & W. M., page 130, Item 12). Letters were read by Dr. Gilman, who stated that Mr. John Mannix of the Michigan Medical Service had wired he would accept the contract sent him, namely, to make a survey of existing California medical service and hospitalization organizations, and that he would endeavor to complete the same within some 60 days.

The advantages of bringing about a closer relationship and harmony between California Physicians' Service and Blue Cross hospitalization groups of California were emphasized.

11. Permanente Foundation:

Association Secretary Kress stated that the Alameda County Medical Association had secured copies of the "Permanente Foundation" papers on file at the Recorder's office of Alameda County. It was agreed that copies of the same should be sent to the members of the Council.

12. Council's Questionnaire to County Societies on Supposed "Doctor Shortage":

Report was made that the replies received from component county societies to the questionnaire, which had been sent to them concerning "doctor shortage," indicated that no very serious public health problems existed in their respective areas. Almost everywhere, however, members of the medical profession are being called upon for increased hours of service, this service being gladly rendered.

13. Annual Session, Los Angeles, Sunday, May 2-Monday, May 3:

(a) A letter was read from the Local Committee on Arrangements, through L. A. Alesen, M. D., Chairman, asking for an appropriation.

Upon motion duly made and seconded, it was voted that a sum not to exceed $700.00 be set aside for use by the Local Committee on Arrangements.

(b) Association Secretary Kress, ex-officio Chairman of the Committee on Scientific Work, reported on the plans that had been outlined for the annual session. There will be three general meetings, to be held on Sunday morning, Sunday afternoon, and Monday morning.

All section meetings will be held on Monday afternoon.

It was stated that the Committee had agred to emphasize the following subjects: (1) communicable diseases (tropical and diseases such as typhus, influenza, and malaria); (2) practical points in civilian disaster relief, with consideration of problems actually found important in disaster, such as burns, shock, and other major points of disaster management; (3) nutrition problems, in relation to acute food shortages and other conditions; and (4) new problems in wartime industry. It was stated that guest speakers of prominence would be invited to take part in the above discussions.

Medical and surgical films, with emphasis upon cinema presentations dealing with the work of the Medical Corps of the Army and Navy, will be presented. Military exhibits will also be on display. The House of Delegates is scheduled to hold meetings on Sunday afternoon and again on Monday afternoon.

The importance of very early transportation reservations by members who contemplate attendance was emphasized. Hotel reservations should also be made, well in advance. (Ed. Note.—Readers are referred to C. & W. M., issue of January, 1943, for detailed information concerning train schedules and hotels. The current April number will carry similar information under the captions: Transportation; Hotels.

14. California and Western Medicine:

(a) Certain advertisements having received criticism by readers of the OFFICIAL JOURNAL, it was agreed that hereafter the former rule should be applied; namely, that changes of text in advertisements, especially in matters of possible controversial nature, should be referred by the Business Manager to the Association Secretary, for decision.

(b) Report was made on the year's experience in printing CALIFORNIA AND WESTERN MEDICINE in a city other than the Association and publication headquarters. Suggestions were made in regard thereto, it being agreed that a fiscal report, in proper form, should be presented, at an early date, to the Executive Committee, for action, and subsequent consideration by the Council.

15. Industrial Welfare Commission—Fee Schedule:

Informal reports, concerning the status of the procedures involved in asking for a revised fee table for medical and surgical services rendered under the rules of the Industrial Accident Commission, were made by Mr. Peart and Mr. Hunton.

16. California State Nurses Association:

Informal report was made concerning recent happenings in some of the California Hospitals as regards increase in wage schedules and in unionization of employees. The importance of the issues involved was emphasized.

17. Medical Practice Act:

Correspondence with members of the Board of Medical Examiners concerning proposed amendments, was presented. It was felt that the general plan outlined by the Board's president, Dr. Percival Dolman, would make it possible for the State Board to hold more frequent meetings, as well as pass upon applicants through mail vote; thus providing a procedure that would go far in meeting any emergencies that have arisen in the past through infrequent Board meetings. It was agreed that there should be no lowering of standards now provided in the Medical Practice Act of California.

18. Retired Membership:

The question of an amendment to the Constitution in regard to Retired Membership was presented. No action taken.

19. Hospital Problems in Riverside County:

Councilor Emmons called to the attention of the Council a situation that had arisen in Riverside County, in connection with the medical service rendered at the Riverside County Hospital.

It was agreed that a special committee, consisting of Councilor Emmons, Dr. L. A. Alesen of Los Angeles, and Executive Secretary John Hunton of San Francisco, be appointed to confer in efforts to bring about a harmonious solution of the problems.

20. Illness of Councilor Frank R. Makinson:

It was voted that Council Chairman Gilman express to Councilor Frank R. Makinson, who was reported as ill in Merritt Hospital, in Oakland, the good wishes of the Council.

21. Appreciation of Services of Charles B. Pinkham, M. D.:

Report being made that Charles B. Pinkham, M. D., had retired at the end of some 30 years as a member of the Board of Medical Examiners and as its Executive Secretary, it was agreed that President William R. Molony should draft a suitable letter of appreciation to be sent to Doctor Pinkham on behalf of the Council.

22. Date of Next Meeting:

It was agreed to hold the next meeting of the Council in Los Angeles on Saturday, May 1, at 10:30 A. M., unless outherwise announced.

23. Adjournment:

Upon motion duly made and seconded, it was voted to adjourn.

PHILIP K. GILMAN, M.D., *Chairman.*
GEORGE H. KRESS, M.D., *Secretary.*

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

Examining Physicians For California, Selective Service Local Boards

*Letter Thereon: From the Honorable Earl Warren, Governor of California**

(COPY)

STATE OF CALIFORNIA
GOVERNOR'S OFFICE
EARL WARREN, *Governor*
Sacramento

February 15, 1943.

Dr. George H. Kress, Secretary-Treasurer,
California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Dr. Kress:

Examining physicians serving with Selective Service Local Boards are nominated by the Governor for Presidential appointment, and Medical Advisory Boards are appointed by the Governor.

I plan to follow a procedure, which in my opinion, will maintain the Selective Service System in our State from all considerations except those essential to the filling of these positions with the best possible personnel.

Briefly, I am asking the various County Medical Societies to shoulder the responsibility of making recommendations for these appointments.

I am doing this because these positions are a matter of community concern, and, therefore, selection should be left as much as possible in the hands of those thoroughly familiar with the profession and with local conditions.

It is not my intention to disturb existing personnel in these positions, or other personnel presently engaged in the administration of Selective Service in the State. My only purpose is to clarify the procedure for filling actual vacancies in these positions as they occur.

I am communicating with you as Secretary-Treasurer of the California Medical Association, trusting that you will be willing to assist by promulgating this plan among the various County Medical Societies and by working out such general rules as may be necessary to carry it out with uniform practice and in a manner that will be understood by all.

I am confident that the County Medical Societies will continue to shoulder this added responsibility as a patriotic duty.

Assuring you that I will appreciate whatever you and the California Medical Association may do to put this program into effect among the County Medical Societies, I am,

Sincerely,
(Signed) EARL WARREN,
Governor.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Asssignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U.S.N. The Senior Medical Officer is Captain John C. Ruddock, U.S.N.R. The office is located at 411 West Fifth Street, N. W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

* For editorial comment, see page 213.

PRO PATRIA

THREE LETTERS FROM SAN FRANCISCO COLLEAGUES

Note. The Editor will be pleased to receive letters from C.M.A. members, who in turn have heard from colleagues in military service. (The original letters will be returned after "copy" has been set in print.)

Members of the Association, who are in service with the Armed Forces in the United States or elsewhere, are also invited to write the Editor concerning their experiences. Colleagues in civilian practice will be happy to hear from them.—Ed.

(COPY)

From W. D. Horner, MC, Naval Hospital, Area Heights, Pearl Harbor, T. H.

Naval Hospital, Area Heights,
Pearl Harbor, T. H.
February 15, 1943.

Dr. George H. Kress,
Editor, C. & W. M.

My dear George:

Thank you so much for your interest in sending me the "Twenty-Five Years Ago" reminder of my first medical paper as a Naval officer in 1917. Little did I think that I would be on an active front of a second war, at that time. If we had done a more thorough job from the armistice on, we might have prevented this one.

I have been over here thirteen months and have enjoyed doing my bit. I am now dividing my time between Ophthalmology practice, and Assistant Executive Officer. As ranking reserve officer in our hospital, I am being drawn more and more into executive work. I like it and find it stimulating and instructive.

As you may have heard, I received my fourth stripe and eagle [eagle is the collar insignia] which pleases me. In 1917 I thought that four stripes was a lot of rank and it seems so yet when I meet a Captain. Consequently, I'm the more proud to be one.

We have a splendid group of San Francisco physicians here and they are doing excellent work. The number includes E. J. Best, Lloyd Reynolds, James Viacelli, Henry Weyrauch, Dudley Bennett, Phil Gilman, Jr., Harold

Hill, Carrol McKenney and Leon Parker.

Kindest regards to you and again thanks for your enclosure.

Sincerely yours,

W. D. HORNER.

(COPY)

From Lieut. Comdr. Harold E. Fraser, MC, U.S.N.R., Dispensary Naval Air Station, Pensacola, Florida

Dispensary, Naval Air Station,
Pensacola, Florida.
Monday, February 22, 1943.

My dear George:

Thought I would drop you a line and say hello. Also to tell you I received the January C. and W. M., which came via Bethesda. If you have any extra copies in the future would appreciate the same sent to Dispensary, Naval Air Station, Pensacola, Florida. Looks like I may be here for some time.

I have had to learn many new things here about aviation because that is the main feature of my work. I am associated here with Dr. Crispell, who was head of neuropsychiatry at Duke University. He has been here for almost two years and has been teaching doctors taking aviation medicine, at the graduate school of the Navy which is located here. In addition he has been handling the problems of aviators and the station personnel. He wants me to take over the teaching, so I have been reading up a great deal. I personally am glad to fall into such a spot, as the work is stimulating.

Pensacola is an old station and everything is flying. The cadets are all boys of higher strata, as you can appreciate when you note the requirements. I live in the town, which is 9 miles from the station. Working hours from 7 a.m. to 3 p.m. daily, except Sunday.

My only regret is to be so far from family and friends. Living conditions are not satisfactory to bring my family here, and Mrs. Fraser, I know, would not be able to stand the hot weather of the summer. So one just has to make the best of it. . . .

Sincerely,

(Signed) HAROLD E. FRASER,
Lieut. Comdr. MC, U.S.N.R.

(COPY)

From Mark Gerstle, Jr., Lt. Comdr. MC, U.S.N.R., Comserfor Sowespacfor, c/o Fleet Post Office, San Francisco

February 24, 1943.

Dearest Dad:

Am certain Martha has sent you copies of my several letters. Can't say much except that it's all pretty grim, vague and disorganized. I'm trying to bolster my morale and do what I can to combat the ennui and nostalgia. Met Neville R.'s sister and just missed young Mortimer F., who could not come ashore here. The weather varies between cool to very hot. The place is packed and very expensive (so Cyril, have asked Martha to ask you to air mail me $500.00 at once—I came prepared for no expenses in the jungle!). I'm feeling fairly well—and have met lots of officers and men from California. Our trip out here was "sumpin"—I'll tell you about it one day. Australia is a cross between Coney Island, Greenwich Village, and Sacramento. Please all write. Have received no word as yet from anyone.

All my love—and Lord knows I need yours!

MARK.

(COPY)

Where Should Physicians Available for Civilian Practice, Locate Themselves?

The following letter has been received from Harold A. Fletcher, M.D., California Chairman for Physicians, Procurement and Assignment Service:

Room 1435, 450 Sutter Street,
San Francisco, California, March 5, 1943.

Board of Directors,
San Francisco County
Medical Society, *Addressed.*

Gentlemen:

Recently I have received complaints from some of my county committees of Procurement and Assignment in neighboring communities because certain physicians from larger communities, such as San Francisco, who have been rejected for a commission in the Armed Forces, have located in these communities where there is no need for added medical care at the present time. Complaints, particularly, have come from San Mateo County and Santa Clara County. It is the feeling of the medical profession in these communities that a large number of their young physicians have left their practices for the duration with the hope that they may return to practice after the emergency without finding their places taken by a newcomer. This hope is shared by the members of county medical societies and various means have been taken to protect physicians who are absent because of military service.

There is a great demand, as we all realize, for physicians in certain areas during this emergency. It is one of the responsibilities of Procurement and Assignment Service to obtain physicians for such areas and we have been working very hard to obtain physicians for replacements where they are most needed. We have endeavored to impress on those physicians who have been rejected for commissions in the military forces, and who wish to relocate, that their first duty is to locate in some area where their services are urgently needed rather than in some area where there is still a sufficient number of physicians and where their services are not urgently needed. Unfortunately, in several such cases, the physician refuses to abide by any suggestions on the part of this office, and in spite of being discouraged by the Procurement and Assignment Committee of the neighboring county, or by the county medical association members of that county, he has gone ahead and relocated where he is not needed or wanted. The Procurement and Assignment Service, at present, has no power or authority to prevent such moves. I have, however, told the county committees of Procurement and Assignment that I felt that the proper pressure on the part of their county medical societies could soon make itself felt if the proper steps were taken to deny membership in their county societies to such physicians who are interested only in becoming located in that area during the absence of the regular medical personnel. In certain cases, undoubtedly, such physicians will already belong to the county medical society in the county from which he is moving. In such cases, I believe that some coöperation between the county medical societies of the two counties involved would be very desirable. I do not know whether any disciplinary action could be taken by the county society in which such a physician was a member, but I would appreciate your consideration of this possibility. It is, however, quite conceivable that the county to which such a physician moves can deny such a physician membership in that county medical society, if for no other reason than the physician is moving against the best interests of the present emergency and the medical profession itself.

I would appreciate it if the Board of Directors of the

San Francisco County Medical Society would discuss this problem and make any suggestions to me which it may deem advisable. This letter may be published in the *Bulletin* if you desire.

Yours very truly,

HAROLD A. FLETCHER, M. D.,
California State Chairman for Physicians, Procurement and Assignment Service.

CC—Dr. Ernest W. Cleary.
Dr. George Kress.

War Conference in New York, May 24-27

The medical, surgical and industrial hygiene experts who are so ably safeguarding the well-being of more than 20 million industrial workers have agreed to pool their knowledge and exchange their experiences regarding the many new and complex problems of today's wartime production. For this purpose their organizations—

The American Association of Industrial Physicians and Surgeons, the American Industrial Hygiene Association, and the National Conference of Governmental Hygienists —are combining their annual meetings in a four-day "WAR CONFERENCE" at Rochester, New York, May 24-27, 1943. Among the problems to be discussed from a practical standpoint are:

(a) The mass entry of women into industry;
(b) Older-age employees, with their various associated problems; proper placement and employability considerations of the 4F rejectees;
(c) Rehabilitation and proper employment of those already discharged from the military services because of disabling conditions;
(d) Toxic and other hazards from new substances, new processes, and the use of substitute materials;
(e) Absenteeism: fatigue; nutrition;
(f) Effects of long hours; double shifts; two-job workers; overtime; increased industrial accident rates;
(g) Advances in the treatment of illnesses and injuries, and many others.

This joint meeting will be a report on the state of the nation, by the men who know, in matters of industrial health. Dr. William A. Sawyer, Medical Director of Eastman Kodak, is General Chairman; Dr. James H. Sterner and Lieut. Comdr. J. J. Bloomfield are arranging the programs for the industrial hygienists.

Physicians and surgeons, hygienists, engineers, nurses, executives—all who are interested in the problems of industrial health and their solution—are invited to attend as many of the sessions as they can arrange for; no registration fee is required.

Many Doctors Slated For '43 Army Duty

Chicago, March 10.—(AP.)—During 1943 the Army plans to commission 6,900 physicians, 3,000 interns and resident doctors from hospitals, 4,800 dentists and 900 veterinarians.

Under a new procedure, the announcement said, none will be commissioned until he has been declared "available" by the Procurement and Assignment Service of the War Manpower Commission. The Surgeon General of the Army has discontinued all medical recruiting boards.

From 20 States

Most of the new army doctors will be obtained from twenty states and the District of Columbia, some states already having filled their quotas.

The twenty states where physicians will be procured were listed as California, Colorado, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont and Wisconsin. . . . —San Francisco *Examiner*, March 11.

U. S. Casualties Total 65,380 in Complete Listing

Washington, February 20.—(UP.)—The Office of War Information reported today that the latest figures available show that casualties of the United States armed forces total 65,380.

The total includes killed, wounded, missing, those interned in neutral countries, and army prisoners of war.

The War Department reported that through February 7, Army casualties totaled 41,948. Of this number 3,533 were killed, 6,509 wounded, 25,684 missing, 6,132 prisoners of war, and 90 interned in neutral countries.

The Navy reported casualties as of February 19, totaling 23,432. This figure includes:

Navy: Dead, 5,083; wounded, 2,087; missing, 10,197.

Marine Corps: Dead, 1,483; wounded, 2,344; missing, 1,994.

Coast Guard: Dead, 51; wounded, 19; missing, 174.

The combined casualty toll for all of the armed forces was given as dead, 10,150; wounded, 10,959; missing, 44,181.—San Francisco *Chronicle*, February 21.

Army Men Are Suffering Fewer Ills

Chicago, March 3.—(AP.)—The *Journal* of the American Medical Association said today men in the United States Army are suffering less from wintertime ailments than the civilian population in some parts of the country.

The *A.M.A. Journal*, in a summary of accomplishments of the medical department of the army since Pearl Harbor, cited figures disclosing the decrease in disease compared to World War I, and declared "the record of the United States Army Medical Corps is one in which we may all take pride."

The number of army men suffering from colds, influenza, pneumonia, and measles this winter are well below the five-year average rate of cases in the army, the *Journal* said, adding that rates for the civil population in some parts of the country are above the five-year average for the nation.

The publication said venereal disease is substantially less than during World War I, and the syphilis rate is the lowest in the history of the army. Excluding battle casualties, the death rate since January, 1941, has been the lowest in the army's history. The *Journal* reported in the last war, 1.1 patients of each three with meningitis died; now only one in 20 dies. It added:

Prompt diagnosis, efficient care and sulfonamides have made the difference. Overseas, such conditions as malaria and dysentery are being fought with all that modern medicine has provided for the army medical armamentarium.

The *Journal* said during the year the only serious incident from a medical point of view was the jaundice associated with innoculation against yellow fever.

When the medical history of World War II is written, the *Journal* said, the first year after Pearl Harbor will be recognized as one in which the medical department of the United States Army was expanded tremendously in personnel, organized units, supplies and responsibilities, and in which it met all these demands quietly and efficiently.—Sacramento *Bee*, March 3.

Defense Hospitals in California

30 Base Units Readied for Any War Emergency

Thirty base hospitals with accommodations for 7,000 patients, and 25 medical teams to man them in event of enemy attack on coastal cities and towns, were designated yesterday by the State Council of Defense Emergency Medical Service.

Patients would be sent to the hospitals after primary treatment in their home communities, under the plan

announced by Thomas F. Clark, State hospital officer for the organization.

The base and affiliated base hospitals are situated in Ukiah, Napa, Sonoma, Santa Rosa, Stockton, Sacramento, Modesto, Merced, Madera, Fresno, Hanford, Tulare, Bakersfield, Camarillo, Patton and Los Angeles. Physical facilities and surgical units dominated the choices.

Hospital care for injured civilians at the base hospitals will be paid for by the U. S. Public Health Service at the rate of $3.75 per patient per day. The medical units, now maintained on the reserve list of the Public Health Service, consists of 15 specialists.

Dr. Fred T. Foard, medical officer for the Ninth Region of the Office of Civilian Defense, said the California base hospital plan was termed the most outstanding in the nation, and particularly important for the safety of civilians because 70 per cent of the State's population lives within 50 miles of the coast line.—San Francisco *Chronicle,* February 10.

Military Clippings—Some news items of a military nature from the daily press follow:

Servicemen May Total 12,000,000

Washington, March 1.—(AP.)—Congress learned today that to maintain an armed force of 11,000,000 men upward of 12,000,000 may have to don uniforms before the war is over.

This 1,000,000-man loss in manpower was attributed largely to normal attrition, exclusive of battle casualties.

In testimony before a Senate Appropriations subcommittee recently, Col. Lewis Sanders, chief of the reëmployment division of the Selective Service, said 12,000,000 men would have to be placed in service to maintain an armed force at all times of 11,000,000 men. He said:

"In other words you would put into one picture an armed force of 11,000,000 and then a million men to replace the attrition of that armed force, which looks as if you have 12,000,000 in service, but you don't. You always have 11,000,000."—Los Angeles *Times,* March 2.

U. S. to Commission Women Doctors

Dallas (Tex.), February 8.—(AP.)—For the first time in the history of the United States Army women doctors will draw commissions and perform the duties of medical officers.

A War Department bulletin announced that the director of the Women's Army Auxiliary Corps would requisition women doctors from the Surgeon General. They will be commissioned as officers in the WAAC.—San Francisco *Examiner,* February 9.

No Discrimination Against Women Doctors, Navy Says

Women who enlist in the Navy as doctors are "just as much a part of the Navy as anyone else," Capt. P. K. Gilman, procurement officer for the U. S. Naval Medical Corps, 12th Naval District, said today in reply to charges by San Francisco women physicians of discrimination against their sex.

The women doctors, seeking to "preserve the equal professional status they have with medical men at home," have joined a national fight for legislative changes to permit them to serve in the Army and Navy Medical Corps at home or abroad.

Captain Gilman said although women physicians are admitted only to the Medical Corps of the Women's Naval Reserve, they receive the same pay, are commissioned as officers with opportunities for promotion, wear a naval uniform and "have the same status as officers as medical men in the Naval Reserve."

He "didn't think," however, they would be allowed to serve overseas and said their duties are confined to treating women.

Three San Francisco women physicians, Dr. Ann Purdy, Dr. Mary Mathes and Dr. H. E. Thelander, yesterday expressed the opinion the Army and Navy were not taking advantage of all available medical skill by not letting women doctors into the regular Medical Corps.—San Francisco *News,* March 18.

Draft to Take 12,000 Men Each Day

Washington, February 13.—(AP.)—The top manpower officials told the American people tonight that 12,000 men a day are going and must continue to go into the armed forces this year and that no man 18 to 38 can be deferred, regardless of dependents, unless his work is essential and he is irreplaceable.

Paul V. McNutt, chairman of the War Manpower Commission, and Maj. Gen. Lewis B. Hershey, director of Selective Service, disclosed the actual rate of inductions in outlining the draft outlook in a joint broadcast over the Blue Network. Heretofore, this rate has been a closely guarded secret but in the telling there was no comfort for the Axis. . . .

Statistics Cited

Statistically, the picture presented by these and past pronouncements was this: A total of about 22,154,000 men, 18 to 38, with 14,000,000 to 15,000,000 able to pass military physical requirements. About 2,500,000 deferred for vital farm work and other highly important war jobs. About 11,200,000 in the armed services by the end of this year. . . . —Los Angeles *Times,* February 14.

Size of Armed Forces to Be Up In Senate

Washington, February 19.—The question whether the armed forces should number less than the 10,700,000 planned by the end of this year will be brought to the fore next week in a special Senate subcommittee, headed by Senator Bankhead (D., Ala.). . . .

Estimated Increases

The WMC analysis estimates that an armed force of 10,700,000 will require a total addition of 6,400,000 to manpower in 1943—4,300,000 in the Army and Navy, 1,800,000 in munitions industries, and 300,000 in essential nonagricultural industries such as food processing, lumber, metal mining, coal mining, oil production, electric and gas utilities, and Government war agencies.

This means an increase in essential manpower from 31,700,000 last December to 38,100,000 next December. The 38,100,000 total is divided as follows: Armed forces, 10,700,000; munitions industries, 10,500,000; agriculture, 8,900,000, the same as 1942; essential nonagricultural industries, 8,000,000.

60 Per Cent of Labor Force

This 38,100,000 to be directly engaged in and supporting the war is 60 per cent of the total estimated labor force by the end of 1943, which is 62,500,000.

The WMC says only half of the 6,400,000 increase can be provided by expanding the total labor force by 2,700,000 persons, mostly women, and by reducing unemployment by 500,000. The other half, 3,200,000, must be drawn from less essential industries.

Transfer of the 3,200,000 "will call for extensive contractions in the civilian economy," the WMC report says, adding that it will be necessary, as well, to make special provisions for facilitating migration to shortage areas.

The WMC estimated that only 500,000 workers would be gained by the 48-hour week.

To meet the farm labor shortage, it recommended transfer of workers from subsistence farms, "additional utilization of farm women and children in the fields," and, for the peak harvest season, "to mobilize townspeople for temporary work in agriculture on a far more extensive scale than was done in 1942."—San Francisco *News,* February 19.

Colonel Wears Lieutenant Bars to Relieve Manpower, Help Win War

Maximum use of available manpower is an Army objective, and placement of persons skilled in professions and trades is sometimes a tough job. But the placement is occasionally easy, as in the case when a man with colonel's wings, his own, pockets them and pins the bars of a lieutenant on his shoulders in order to qualify for an assignment with Uncle Sam. Such Army spirit works quietly today.

Dr. Philip S. Potter, former college professor and author of texts on pediatrics, was practicing in Berkeley, Calif. He had in 24 years work advanced to the rank of colonel in the Army Medical Reserve Corps, which he entered upon discharge as a captain when he returned from Europe after the 1918 Armistice. He had been an Army surgeon at Evacuation Hosnital No. 20 at the Meuse-Argonne in France. But this modern global war was about to leave on the sidelines Dr. Potter. Anno Domini is against him this war. He is confident that he could serve with troops, but the Army says his years are too

many. So he is not called to active duty in his rank of colonel.

But he can serve—Dr. Potter is sure of that. He does his bit about manpower. At almost 68 years of age he found a niche at California Quartermaster Depot, with headquarters in Oakland, California.

The status of the position this physician found is that of a civilian, yet he ranks as a first lieutenant—and no lieutenant wears his rank better.

From the silver eagles of a colonel to the bars of a lieutenant is a transition of several grades, yet Dr. Potter is enthusiastic about his present assignment. His depot service in the present capacity releases a younger medical officer for duty with troops and wherever the combat front may be.

Identification Cards For Diabetics

A special identification card for diabetics is to be distributed to physicians by the Emergency Medical Service and then on to San Francisco's 4,500 persons with diabetes.

The announcement was made yesterday by Dr. Henry Gibbons, III, chief of this Civilian War Council Service, who said the card has been developed as special identification in the event of air raids.

Said to be the first plan of its kind in this country, the cards are expected to reach patients immediately after distribution is completed to physicians in about two weeks. —San Francisco *Chronicle,* March 1.

Hospital Spas for Service Men

A silver lining has manifested itself in the cloud overhanging California resorts, at least those situated near mineral springs. The cloud has been dense, with gasoline rationing, and the plans of many city people to spend their holidays working in the harvests.

Now Dr. George H. Kress of San Francisco, a former president of the California Medical Association, and a real influence in medical circles, proposes that hospitals for the rehabilitation of injured service men be located in areas where natural mineral springs will provide opportunity for thermal procedures.

Communities having such natural resources should start now to interest governmental agencies in providing "hospital spas" for service men. This would help meet America's obligations to her heroes and, in the long run, would establish California's resorts on a par with Europe's famed spas for the benefit of civilian citizens of all states.

It seems as if the Sonoma Valley Chamber of Commerce had the right idea when it advocated the mineral springs development here for government hospitals to care for injured or sick men home from war.... —Sonoma *Index-Tribune,* February 19.

COMMITTEE ON INDUSTRIAL PRACTICE

Re: Free Choice of Physicians in California Accident Cases

At the C.M.A. Council meeting on February 28, 1943, President Molony, of Los Angeles, suggested that consideration be given to the adoption of legislation providing for a free choice of physicians in industrial accident cases. His reference was particularly directed toward the provisions of this character in the New York Workmen's Compensation Laws.

The Committee on Public Policy and Legislation, through Dwight H. Murray, M.D., Chairman, of Napa, sent to C.M.A. Councilors a copy of the provisions of the New York law regarding choice of physicians and allied matters, with request for study of the provisions.

Request was made for Councilors' opinions on the matter, to permit the Committee on Public Policy and Legislation to endeavor to take such steps as might be possible to carry out the wishes of the Council.

Members of the California Medical Association are invited to send suggestions to Doctors Molony and Murray, whose addresses appear in the State Medical Directory, a copy of which is sent each year to all California licentiates.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

California's Medical Practice Act

Proposed Amendments Thereto

The following summary, concerning proposed amendments to California's Medical Practice Act, designed to make it possible for the State Board of Medical Examiners to examine applicants for licenses with a minimum of delay, have been submitted by Percival Dolman, M.D., President of the Board.

Quotations follow:

Assembly Bill No. 1171—(Mr. Potter)

This bill seeks to put into the Code certain Board duties covered now by Board rules and resolutions only. Duties concerned with the consideration of and prompt action upon the credentials presented by an applicant for a license to practice medicine in California are among the most important obligatory actions of the Board. This bill will legalize the appointment of a Credentials Committee by the Board President and will legalize the procedure whereby the action of the Credentials Committee on applications is transmitted in writing to the Board members for their consideration; and further provides that a written vote on the recommendations of the committee may be sent by Board members through the mail to the Secretary of the Board. At present the recommendation of the Credentials Committee must be approved at a called Board meeting, which procedure is slow and expensive. The vote of the Board members by mail will aid the Board in speeding up the routine of getting applicants licensed and into practice in California. *This is an urgency measure.*

* * *

Assembly Bill No. 1172—(Mr. Potter)

This bill amends Section 2365 and 2366 of the Business and Professions Code by reducing the time between the issuance of a citation and the time it is returnable at the next Board session to 15 days, and cuts the time during which Respondent must file an answer from twenty to ten days. These cuts in time will speed up action on citations and do no harm to the licensee involved. At present no citations issued within 30 days of a Board session may be acted on by the Board, and must go over several months to a subsequent Board meeting.

A new section, 2366.5, is added to the Code, authorizing the service of citations by registered mail directed to the licensee's last address registered with the Board. This stops the escape of service by hiding from and evading the person who seeks to serve the citation.

* * *

Assembly Bill No. 1173—(Mr. Potter)

This bill seeks to prevent an evil practice often resorted to by the attorney who is defending an abortionist. The chief and best prosecuting witness in an abortion case is the woman upon whom an abortion has been performed. When the defense threatens her with criminal prosecution for seeking or consenting to a criminal abortion, she frequently refuses to testify against the defendant physician. If she so refuses, the Board must delay further action against the physician until the statute of limitations has run against the woman.

* * *

Assembly Bill No. 1174—(Mr. Potter)

It has been the Board practice for years to restore certain revoked licenses upon proper showing and consideration, after the lapse of one year. It has been pointed out

to the Board that the legal right of restoration of licenses does not exist in the Code and that our past procedure of so doing has been under Board rule or resolution only. The act of restoring revoked licenses and the procedure therefore will be made legal by this bill.

There is no doubt in the minds of the Board members that they should have the right to restore revoked licenses after careful consideration of the merits of each case.

* * *

Assembly Bill No. 1175—(Mr. Potter)

At present, an applicant for a California license must show that he had in his possession a diploma before being admitted to examination. Many medical schools withhold the actual diploma for a varying period of time after the examination, but do issue a certificate upon completion of the course of study. This bill enables the Board to recognize a diploma "or other evidence," etc., and this corrects the restrictions imposed by the use of the word "diploma" alone.

What the Los Angeles County Medical Library Means to Some Members

In the *Bulletin of the Los Angeles County Medical Association,* of March 18, 1943, is an interesting article by Louis J. Regan, M.D., and Eugene R. Purpus.

What is stated concerning the library of the Los Angeles County Medical Association applies in equal measure to the medical libraries of the University of California and of Stanford University; in lesser degree, perhaps, to the smaller libraries of the Alameda County Medical Association, the San Francisco County Medical Society, the San Diego County Medical Society and the Riverside County Medical Society.

In each issue of California and Western Medicine, on advertising page 5, appears the addresses of the three major libraries, attention being called to the fact that these institutions are happy to render packet library service to members of the California Medical Association.

Perusal of the comments by Doctors Regan and Purpus should be of interest to all members who avail themselves of medical library facilities:

The true value of any of man's inventions depends to a very large degree upon the ability and understanding of the person who is using it. For some people, a block and tackle would represent nothing more than a confusing conglomerate of wood, metal and rope. For others, those who understand its use, the block and tackle is a means of accomplishing seeming miracles. Similarly, the doctor's surgical kit would, in the hands of the average layman be of little more use than a knife, a scissors, and a nutpick. But the medical man who is trained to use these surgical instruments can perform wonders.

So it is with libraries. Even the most limited of libraries can be of inestimable service to those who have the ability to exhaust its every possibility. The library which is rich in both materials and services offers virtually unlimited opportunities to the individual who knows how to make full use of its facilities.

The members of the Los Angeles County Medical Association are extremely fortunate to have at their disposal what is nationally recognized as one of the best medical libraries in the United States. Our library houses almost 65,000 volumes, and is growing so rapidly that during the last six months more than 4,000 books were added. At the present time, the library regularly receives almost 400 current journals, including 100 foreign journals from all over the world. In addition, an exchange service is maintained with approximately 250 other medical libraries which are component units of the National Medical Library Association.

However, even so well equipped a library is of limited use to those who are not sufficiently well acquainted with its many services. At least two of these are of vital interest to Association members who have difficulty in getting to the library or who are too hard-pressed for time to engage in necessary research.

For members who are outside the city, especially those who are in the armed services all over the world, and for military medical personnel generally throughout California, Utah, and Nevada, the library offers a very liberal mailing service. The library staff will be glad to mail to you those books or periodicals which you request.

For those doctors who cannot work at the library in person, and particularly for those who cannot spare time to do their own searching for materials on the problems which interest them, the Reference Department can be of special service. The function of this department is to survey the literature on any subject requested by a physician and to select books and articles which will be of most help to him. The entire staff of the library is most amiable, helpful and capable. The tradition of fine service rendered by Mrs. Mary E. Irish has been carried on by the present librarian, Miss Hazel Granger. The five librarians and one secretary employed by the library have an aggregate of more than sixty years of medical library experience. They are more than able to serve you—they are anxious to help you make the best possible use of the facilities which the library has to offer.

During the past year, 18,000 visitors were given service in the library—2,000 of these during evening hours. More than 7,500 references, 16,000 books and journals were circulated, and 400 parcels were mailed out to some 150 members. This represents a great service, but one which is relatively small in terms of what the library has to offer. Apparently a large number of the members of the Association have but limited knowledge of their library and its wealth of resources and services.

Your library is an excellent tool which is capable of many uses. Are you using its many facilities to your fullest advantage?

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Mental Clinic Dedication Set

The new Langley Porter Clinic, built by the State and to be operated coöperatively with the University of California, will be officially dedicated at the University Medical Center here Saturday, it was announced yesterday.

The new half million dollar hospital, devoted exclusively to the treatment and prevention of mental diseases, will give California the largest and most modern neuropsychiatric institution west of Chicago.

At Medical Center

Christened the Langley Porter Clinic for the dean emeritus of the University of California School of Medicine, and under construction since 1941, the four-story, ultra modern building stands on ground adjoining the University medical center at Third and Parnassus Avenues. It will accommodate 100 patients.

State and University officials, as well as California civic leaders will attend the dedicatory ceremonies, to extend through the afternoon and evening. On Saturday morning, the new structure will hold "open house" to the public from 9 a.m. to noon.

Two Ceremonies

Mrs. Dora Shaw Heffner, as director of institutions,

* For editorial comment, see page 216.

will preside over the afternoon portion of the ceremonies, and Dr. Robert Gordon Sproul, president of the university, will direct the evening portion. Ceremonies will be held in Toland Hall of the nearby University Medical Center, since no room in the new clinic is large enough to accommodate invited guests.

Dr. Karl M. Bowman, a University of California graduate who until recently headed the division of psychiatry of New York's Bellevue Hospital, will head the clinic as medical superintendent.—San Francisco *Examiner*, February 8.

New Hospital Proposed for Southern California

An $850,000 acute neuropsychiatric hospital for Southern California is part of the 10-year postwar construction program of the State Department of Institutions, it was revealed today by Dr. F. O. Butler, until recently acting director of institutions, in an address which was part of the ceremonies opening the new $500,000 Langley Porter Clinic.

Dr. Butler, superintendent of the Sonoma State Home for Feebleminded, said the new institution would be established "preferably" in connection with the University of California at Los Angeles.

He spoke to a gathering presided over by Mrs. Dora Shaw Heffner, newly-appointed director of institutions. The new San Francisco institution will be devoted exclusively to the intensive treatment of acute cases of mental illness and to special activities in the fields of research, teaching and prevention of mental disorders.—Los Angeles *Times*, February 14.

Hospital Bed Scarcity Hit

Situation Called Critical at Nine Institutions

Nine of the city's principal hospitals are critically short of beds, declared Thomas R. Knudsen, chairman of a committee of representatives of these hospitals, last night at a special meeting at the Ebell Club.

"If we were the size of San Francisco, our hospitals would be almost adequate for normal needs, but would still lack facilities for the emergencies of a Pacific Coast city during wartime," Knudsen said.

"Today, with almost three times the population of San Francisco, our lack of hospital facilities is nothing short of tragic," Knudsen declared. "In fact, a great disaster or even a mild epidemic, with hospitals already filled to capacity, might lay us open to charges of criminal neglect."

City Ranks Last

He said a survey made last fall revealed that, among major cities in the nation, Los Angeles ranked last in the number of beds in its voluntary general hospitals on the basis of population.

"Los Angeles has but 1.51 beds in its voluntary hospitals per 1,000 population, while hospital authorities recommend at least three per 1,000 population in industrial cities," Knudsen said.

He added that Los Angeles newspapers called attention to the critical shortage of hospital beds here two years ago.

"It is high time that those of us who sit on the boards of these institutions make positive steps to correct this dangerous condition," Knudsen said.

Directors Attend

Directors, medical staff members and administrators from the California Lutheran, Cedars of Lebanon, Good Samaritan, Methodist, Monte Sano, Presbyterian, Queen of the Angels, St. Vincent's and White Memorial Hospitals attended the meeting.

Dr. L. A. Alesen, secretary of the County Medical Society, called upon the directors of the hospitals, physicians practicing in these institutions and all residents of the community to feel responsible for helping the hospitals meet their problems. . . . —Los Angeles *Times*, March 16.

Army Gets Dante Hospital in San Francisco

Despite the opposition of the County Medical Association, the United States Army, through Federal District Court order, today was in possession of Dante Hospital.

Controversy over Dante Hospital ended late yesterday when Judge Louis Goodman signed an order for immediate possession. The order was directed against the Dante Hospital Association and the Wells Fargo Bank and Union Trust Co., as owners.

Preparations are being made to remove the civilian patients. This will take two or three weeks, after which the hospital will be used for military personnel at the Port of Embarkation, Camp Knight and Fort Mason.

Much bitterness marked the transfer, the County Medical Association contending that the hospital was needed by civilians. Hospital authorities, however, claimed it was not needed by civilians and pointed to the fact that it was in the hands of creditors.—San Francisco *News*, February 19.

Museums vs. Hospitals: San Diego Problem

Something is happening in San Diego that can bear a little watching.

About 10 days ago representatives of the United States Navy informed Walter Cooper, City Manager of San Diego, that the navy desires to take over the city's three museums in Balboa Park and turn them into hospitals. The navy intimated but did not guarantee that it would assist in finding new quarters for the collections now housed in the Gallery of Fine Arts, the Museum of Man and the Natural History Museum, although it would appear that no quarters even remotely suitable can be found.

This is the first instance on the Pacific Coast, at least, of educational institutions of this kind being requested to close their doors because of military necessity. The museums of Honolulu are running as usual, and none other in this part of the world has been threatened, so far as I know.

The affair seems to be a perfect example of what the National Resources Planning Board had in mind when, some time ago, it issued a warning against the misuse of museums for other purposes than those for which they were created.

The immediate result in San Diego was the passage of a resolution by the City Council empowering Mr. Cooper to negotiate, if possible, with the navy for some alternate solution of the problem. As one San Diego official with whom I talked expressed it: "We are not protesting. We simply feel there must be another way out and we want time to find it."

This official also said there was land available in a convenient and appropriate place for a new naval hospital, and that labor and materials were also to be had. He further stressed the fact that the museums remain the only centers of recreation in Balboa Park, the rest of which has been taken over entirely by the navy. The Gallery of Fine Arts has been conducting free classes among the navy personnel, with large attendance.

Offhand one would think that a museum building would be very badly adapted to the purposes of a hospital. The transformation would require the installation of an infinite amount of equipment and the complete remodeling of interior arrangements; one wonders if, in the climate of San Diego particularly, it would not be quicker, cheaper and more efficient to build new hospitals rather than reconstruct the museums as such. To judge from what the San Diego people have to say, the navy has given no evidence of having considered that alternative before making its demand.

One of the most troublesome aspects of the whole thing is that if the plan goes through these museums will probably be rendered permanently unfit for their original purpose. There is going to be need for naval hospitals after the war as well as during the war; the navy would probably not relinquish them for a very long time, and

a good deal can happen to them in the interim. Money for new museum structures is certainly nowhere in sight at the present moment, and no one can predict when it will be.

Anyhow, it is a situation in which only decisions can be hasty, and it could set an extremely unfortunate precedent, not only for the Pacific Coast, but for the entire country.—Alfred Frankenstein, in San Francisco *Chronicle*, March 15.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Location and Movement of Physicians, 1923 to 1938 —Effect of Local Factors Upon Location

The U. S. Public Health Service in its December 18, 1942 issue of *Public Health Reports,* presents an illuminating survey concerning location and number of physicians for the period 1923-1938, and the effects of local factors as determining elements in change of location of physicians. The survey was made by Joseph W. Mountain, Assistant Surgeon General, Elliott H. Pennell, Statistician, and Virginia Nicolay, United States Public Health Service. Excerpts follow:

* * *

In earlier articles the authors of this series expressed quantitatively the uneven distribution of physicians. More specifically, there was revealed a paucity of provisions for professional services in states where the per capita income was low and where a large fraction of the population resided in rural areas. This situation was more serious in 1938 than in 1923, but seemed to be mitigated to a slight extent in those depressed areas which were favored by the presence of hospitals—especially those offering opportunities for intern training.

With the large and rapidly accelerating withdrawal of physicians from private practice to meet the exigencies caused by the war effort, data depicting the distribution of physicians assume particular significance in defining areas in which civilian health and morale would be least affected by further drafts. It may also be anticipated that the factors which determined the location and subsequent migration of physicians after the first World War will be operative in the period of readjustment following the current crisis unless some efforts are made to understand and direct the forces which have precipitated these distributional trends. . . .

It is recognized that scarcely any particular class of local political subdivision may be considered as representing a self-sufficient area in the provision of service such as medical care. On the other hand, a county usually encompasses a sufficiently large population group to permit the computation of reliable indices, and at the same time to provide community data which are essentially local in scope.

Among the several factors investigated, community wealth was found to be of paramount importance in determining the availability of physicians. The measure of wealth for classifying counties was obtained by dividing the 1940 effective buying income in the county by the population.

In the aggregate, the physician-population ratios for counties showing population increases in both intercensal periods 1920 to 1930 and 1930 to 1940 were high at the initial and terminal years of the study period and a moderate increase appeared during the interval. This was true of both total physicians and new registrants.

Further classification on the basis of income indicates that the high and increasing ratios in counties with expanding populations as revealed in the consolidated figures reflect the dominant influence of wealthy counties.

These disclosures suggest that consistent population increase in areas reflects factors which serve to attract physicians, but only when the income in these areas is high.

The lack of facilities for professional care of ill persons in counties may simply mean that those in nearby areas serve satisfactorily the residents of a county. However, generous facilities within a county may have developed because patients in large numbers are attracted thereto from adjoining or even from distant areas. The definition of counties, or groups of counties which represent both facilities and the population served thereby, is not strictly possible inasmuch as service areas are not always conformable to the boundaries of established political units. Exception may occur where special services are provided at public expense, and where residence within the areas has been established as a prerequisite in eligibility for care.

In modern medical practice the hospital is an invaluable adjunct. Such an institution affords means for the accurate diagnosis and proper treatment of illness, and in many cases is essential for the care and recovery of patients. Absence of hospital facilities in a county may not always indicate a lack of accommodations accessible to those needing care, because one or more hospitals may exist in nearby areas.

Another important adjunct to the practice of modern medicine is the accessibility of professional associates for consultation and exchange of professional ideas. The opportunities for consultation and collaboration in the care of obscure conditions become greater as the number of physicians in an area is increased. Where the provisions for medical care in a county are limited to a small number of physicians the opportunities for interchange of professional ideas are fewer than in counties where the number of physicians is large.

SUMMARY

The data presented reveal much greater concentrations of physicians in some counties than in others. Throughout the comparison, wealth is a dominant factor in the maintenance of high physician-population ratios. Where wealth is high the ratios in 1923 were elevated and tended to remain fixed or even to expand by the termination of the 15-year period. In poor counties, on the other hand, the ratios in the initial year were low, and as a rule were seriously reduced by 1938. This phenomenon was revealed in an even more dramatic fashion for physicians under 45 years of age.

While metropolitan and urban character of counties, facilities as revealed in a count of total beds in general hospitals, and physicians in a county are closely allied with wealth, these factors in isolation also tend to induce larger physician-population ratios at all income levels.

Where income is high and the classification on the basis of other factors used to describe features making counties attractive to physicians is also high, the physician-population ratios are several times as great as in those counties falling lowest on the comparison scales. The number of physicians under 45 years of age per 100,000 population in these most favored classifications generally exceed the ratios based upon total physicians in the poorest counties. It is apparent that the great reservoir of physicians is in the large urban centers. If the ratio of physicians to population in the nonmetropolitan counties were taken as a base, one would find a marked excess of physicians in the larger urban centers and the counties immediately adjacent. Throughout the study period, which embraces a complete economic cycle, there has been a more pronounced tendency for physicians than for the general population to concentrate in urban areas.

COMMITTEE ON MEDICAL ECONOMICS

Doctors Given Hearing on Fees

Doctors who have long sought an increase in minimum rates for treating cases under the State Workmen's Compensation Insurance and Safety Act on February 16th, were given their first public hearing in approximately a decade, by the Industrial Accident Commission.

Present rates, which were fixed and can be altered by the Commission, have been in effect since 1920.

Commission Chairman Paul Scharrenberg, appointed recently by Governor Earl Warren, indicated other hearings may be held before any action will be taken.

Doctor Members of Army, Navy Reserve Exempt From Fees

Members of the medical profession serving full time on active service in the Naval Reserve or the reserve forces of the Army, are not subject to the payment of the Business and Professions Code annual tax or registration fee, according to an opinion by Robert W. Kenny, Attorney-General.

Kenny pointed out that the Naval Reserve is a component part of the United States Navy and is under the jurisdiction of the Secretary of the Navy, and likewise held that the reserve forces of the Army are a component part of the Army.

"The activities of those members of the reserve corps," said Mr. Kenny, in his opinion to the Board of Medical Examiners, "who are on active duty, are not different from the activities of those of the regular Army or Naval service."

He, therefore, held that such reserve groups were specifically exempted under the Business and Professions Code.

Included in the same exemption, according to Kenny, were those serving in the Public Health Service.

Yale Professor Assails State Medicine Plans

James A. Hamilton, president of the American Hospital Association of Chicago and a professor at Yale, thinks "state medicine" which people are saying is just around the corner, is a weasel word.

The issue, he said upon arrival here yesterday, is between voluntary and compulsory medical care.

Hits Implications

"State medicine," he said, at the Biltmore, "implies all sorts of things that are not correct, for instance that it is something free. The American hospitals have the Blue Cross prepayment plan for hospital service and here in California this is sold in the same package with the California Physicians' Service for medical care.

"You pay a fixed sum a year for a fixed amount of services.

"I hold that this is along the right road and the fact that 11,000,000 people in the country are enrolled in the Blue Cross plan should indicate the possibility of its application.

Opposes Green Bill

"One out of 10 people in the country go to a hospital in a year."

Hamilton doesn't like the Green bill which is now before the Senate and which would extend the social security plan to include deductions for hospital service—it wouldn't provide for medical service.

He points out that compulsory hospital service is not included in the famed Beveridge Plan in England, a broad social security plan considered prophetic in this country.

Sees Increased Cost

"A compulsory hospital service," Hamilton declared, "is bound to increase its cost and decrease the quality of care. In this country leadership in hospitals has been in private, not government hospitals; the reverse has been the case in Europe.

"The essential thing now is to extend the services to districts which have none."

Hamilton came here to address a meeting last night of the Hospital Service of Southern California, which operates under the Blue Cross plan and to confer with hospital administrative executives in this district.—Los Angeles *Times*, February 23.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Changes in Mortality Rates in the United States,—Period 1930 to 1940

An article by Harold F. Dorn (United States Public Health Service), in the December 4, 1942 issue of *Public Health Reports,* contains the interesting statements which appear below.

* * *

The decade 1930 to 1940 is the first for which mortality records have been available for the entire country.

CHANGES IN EXPECTATION OF LIFE

Total population.—Between 1930 and 1940 the expectation of life at birth of the total population increased from 59.0 to 63.3 years, an increase of 4.3 years or 7 per cent. Increases occurred throughout the entire life span, the average increase being about 5 per cent. At the beginning of the century, 40 years previously, the expectation of life at birth for the population of the original registration states was 49.2 years; the corresponding figure in 1939, 63.3 years, represents an increase of 14.1 years, or 29 per cent. . . .

Changes in white and nonwhite populations.—During the past decade the percentage increase in expectation of life was more than twice as large in the Negro as in the white population. . . .

CHANGES IN MORTALITY RATES

All causes.—Age specific death rates more directly show the change in mortality at individual ages than does the expectation of life since the latter reflects the relative number of deaths not only at a given age but also at all older ages. . . .

Specific causes of death.—Significant decreases in mortality rates were recorded for each of the important causes of death except heart disease, cancer, and diabetes. The largest relative increase was in the death rate for diabetes which was 12 per cent higher in the white and 24 per cent higher in the nonwhite population in 1939 as compared with 1929-31. Smaller increases took place in the mortality rates of heart disease and cancer; the rate of the former actually decreased in the nonwhite population. The reasons for the observed increases in the death rates from cancer, heart disease, and diabetes are difficult to determine. More accurate diagnosis, a change in methods of entering the cause of death on the death certificate, and perhaps a real increase in the disease itself may all have contributed to the higher death rate.

Large decreases were recorded in the death rates from the principal respiratory causes of death: influenza, pneumonia, and tuberculosis. The decline in the death rate from tuberculosis is a continuation of the trend observed

during recent decades. The lower rate from pneumonia undoubtedly was the result, in part at least, of an increasingly widespread use of serum and drugs in the treatment of this disease. It should be noted, however, that the death rate from influenza also decreased very sharply during the past decade. Part of this decrease may be attributed to the fact that although the number of cases of influenza was higher than the average during 1939, the disease was not especially fatal so that the death rate remained relatively low.

One of the most gratifying features of the past decade was the uninterrupted decline in the maternal mortality rate which previous to 1930 had shown no decline since the birth registration area was established in 1915. During the past decade this rate declined 48 per cent among white mothers and 34 per cent among nonwhite mothers. In 1940 the two rates were 3.2 and 7.7 per 1,000 live births, respectively.

The number of infant deaths dropped below 5 per cent of the number of live births for the first time during the past decade. The relative decrease, 28 per cent, was the same for both white and nonwhites but the rate for the latter is still much higher than that of white infants, 74 per 1,000 live births compared with 43 per 1,000 live births.

Taken as a whole the mortality record of the past decade is one of the most favorable in the history of death registration in this country.

SUMMARY

Between 1930 and 1940 the expectation of life at birth for the total population increased from 59.0 to 63.3 years, or 7 per cent. Increases occurred at each age, the average being about 5 per cent.

The relative increase in life expectancy was nearly twice as great for nonwhites as for whites. The expectation of life at birth increased 3.5 and 4.3 years for white males and females but 4.4 and 5.7 years for Negro males and females. However, the life expectancy for white persons is still appreciably greater than that for nonwhite persons. The expectation of life at birth is 63 years for white males and 67 years for white females, compared with 52 years for Negro males and 55 years for Negro females.

After adjustment for changes in age distribution the death rate from all causes in 1939-40 was about 12 per cent lower than the rate in 1929-31 for whites and about 20 per cent lower for Negroes.

The largest relative decreases occurred in the death rates of children and young adults but significant decreases were recorded throughout the entire life span even among persons in the older age groups.

With the exception of the death rates from heart disease, cancer, and diabetes, the mortality rate for each of the important causes of death was lower in 1939 than in 1930.

For the first time in the history of the registration area, the maternal mortality rate declined uninterruptedly throughout the entire decade. The relative decrease was 48 per cent among white mothers and 34 per cent among nonwhite mothers.

By the end of the decade the mortality of white infants had dropped to 4 per cent while that of nonwhite infants had dropped to 7 per cent.

COMMITTEE ON POSTGRADUATE ACTIVITIES

Eleventh Annual Clinical Congress: C.M.E.

In spite of wartime conditions the four medical schools located in California continue their efforts to promote interest in after-graduation courses. On Sunday, March 21st, in Paulson Hall in Los Angeles, the College of Medical Evangelists, under the auspices of its Alumni Association, presented its Eleventh Annual Clinical Congress. For the information of readers, the program follows:

SYMPOSIUM:

"PRACTICAL POINTS IN THE DIAGNOSIS OF RECURRENT AND CHRONIC ABDOMINAL PAIN"

9:00—Thoracic Viscero....Walter E. Macpherson, M.D.
9:15—Stomach and Duodenum.....James Cryst, M.D.
9:30—Biliary Tract.....Charles A. Bachhuber, M.D.
9:45—Small and Large Bowel.Daniel D. Comstock, M.D.
10:00—Pancreas.....George Thomason, M.D.
10:15—Female Pelvis.....Roy E. Fallas, M.D.
10:30—Urinary Tract.....R. Theodore Bergman, M.D.
10:45—Nervous System.....Cyril B. Courville, M.D.
11:00—Psyche.....Clarence E. Olsen, M.D.

Intermission

11:20—"The Stader Fracture Treatment for Early Mobilization of Patients"—Comdr. Frank Kreuse (MC) U.S. Naval Hospital, San Diego, Calif.

11:50—"Observations of the Kenny Treatment of Infantile Paralysis"—J. Wayne McFarland, M.D.

12:05—"Rôle of the Anal Glands in the Pathogenesis of Anorectal Disease"—Malcolm R. Hill, M.D.; E. Harold Shryock, M.D.; F. George ReBell, M.D.

12:20—"Obesity in Children"—Belle Wood Comstock, M.D.

12:30—Dinner

CLINICAL DEMONSTRATIONS AND SCIENTIFIC EXHIBITS AT THE DISPENSARY

Continuously 2:00 to 4:45 p.m.

Cardiology
"Hyperventilation Syndrome"—Commonly Diagnosed as Heart Disease—William Paul Thompson, M.D.
"The Diagnosis and Treatment of Angina Pectoris"—Donald E. Griggs, M.D.
"Newer Cardiac Drug Therapy"—Ralph M. Tandowsky, M.D.
"Roentgenology in the Diagnosis of Heart Disease"—Walter L. Stilson, M.D.

Dermatology
"Dermatoses Common Under War Conditions"—Lantern Demonstration—Samuel Ayres, Jr., M.D.; Nelson P. Anderson, M.D.
"Common Skin Diseases"—Lantern Demonstration—Paul D. Foster, M.D.; Molleurus Couperus, M.D.

General Surgery
"Plastic Surgery of the Breast"—"Abdominal Linectomy"—"Treatment of Axillary Scars"—Motion Pictures and Exhibits—2:00 p.m.—Harold I. Harris, M.D.
"Chest Surgery"—Motion Pictures—3:00 p.m.—Wilfred M. Jones, M.D.
"The Diagnosis of Varicose Veins"—"The Surgical Treatment of Varicose Veins"—Motion Pictures—4:00 p.m.—Alfred E. Gilbert, M.D.

Gynecology and Obstetrics
"Cervical and Vaginal Lesions"—Lantern Demonstration—"Sacral Block"—Demonstration—"Sub-Total Hysterectomy"—"Vaginal Hysterectomy"—Motion Pictures—William C. Bradbury, M.D.; Harold F. Ziprick, M.D.; Virgil O. Parrett, M.D.
"Tubal Insufflation"—Exhibit—Almond J. Balkins, M.D.

Ophthalmology
"Presentation of Interesting Eye Cases"—"Kodachrome Clinic"—William A. Boyce, M.D.; Harold F. Whalman, M.D.; Paul V. Yingling, M.D.

Orthopedic Surgery
"Manipulative Therapy"—G. Mosser Taylor, M.D.
"Orthopedic Office Treatments"—Fred A. Polesky, M.D.
"Fracture Symposium"—Comdr. Rudolph Joldersma (MC) U.S. Navy; Charles W. Gilfillan, M.D.; C. Cornell McReynolds, M.D.

Otolaryngology
"Surgery of the Sinuses"—Motion Picture Demonstration—Benton N. Colver, M.D.; Charles E. Futch, M.D.; Leland R. House, M.D.; Lloyd K. Rosenvold, M.D.
"Normal Physiology and Pathological Lesions of the Larynx"—Motion Picture Demonstration—Joel Pressman, M.D.
"Cosmetic Repair of Facial Defects"—Demonstration of Plastic Art—Leopold Dreifuss.
"Bronchial Pulmonary Tumors and Bronchoscopy"—Demonstration—H. N. Mantchik, M.D.
"Fascial Spaces of the Neck"—Anatomical Demonstration—Milo C. Schroeder, M.D.; Leland R. House, M.D.

Anatomical and Photographic Specimens on Display.

Physical Therapy
"Treatment of Infantile Paralysis"—Demonstration of Cases—J. Wayne McFarland, M.D.
Proctology
"Rôle of the Anal Glands in the Pathogenesis of Anorectal Disease"—Exhibit—Malcolm R. Hill, M.D.; E. Harold Shryock, M.D.; F. George ReBell, M.D.
Psychiatry
"Electro Shock Therapy"—Motion Picture and Demonstration—Clarence W. Olsen, M.D.; Byron L. Stewart, M.D.; B. Clemson Marsh, M.D.
Roentgenology
"A Study of Roentgenanatomy of the Lungs and Illustrative Cases of Various Types of Pneumonias"—Walter L. Stilson, M.D.; Otto J. Neufeld, M.D.; Paul H. Deeb, M.D.
Urology
"Bladder and Urethral Disorders in Women"—Lantern Demonstrations—2:00, 3:00 and 4:00 p.m.
"Urological X-ray Diagnosis"—2:30 and 3:30 p.m.—Roger W. Barnes, M.D.; R. Theodore Bergman, M.D. Paulson Hall—5:00 to 6:30

American College of Surgeons

Regional Meetings

Attention is called to the following regional meetings:

Date	*City*	*States*	*Headquarters*
Tuesday, April 13	Los Angeles	So. California, Arizona	Biltmore Hotel
Friday, April 16	San Francisco	No. California, Nevada	Fairmont Hotel

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Mobilization of Nurses Is Urged

Measures to protect civilian health by stretching medical care in California were recommended yesterday by the Northern California coördinating committee of the Procurement and Assignment Service for physicians, dentists and veterinarians.

The measures include mobilization of nursing power, training of auxiliary nurses and elimination of luxury nursing services.

Competent nurses can increase the work capacity of physicians and conserve their services for the acutely sick, the committee believes. It urged:

1. That registered nurses perform only those functions in the care of the sick requiring professional skill and that, in addition, they supervise trained auxiliary workers performing duties requiring less highly-trained personnel.
2. That all currently inactive nurses, including those married in other occupations, return to nursing duty.
3. That nonessential nursing services be eliminated.
4. That more student nurses be recruited.

Other recommendations seek the elimination of duplication in public health nursing services and coöoperation between physicians and nurses to meet the health needs of the people.—San Francisco *Chronicle*, March 1.

O.C.D. Medical Chief Asks Aid From Public

Washington, January 23.—(AP.)—Predicting America will have a shortage of doctors and nurses throughout the war and for some years to follow, Dr. George Baehr, chief of the medical division of the Office of Civilian Defense, appealed to the public today to dispense with "luxury medical attention."

He listed as luxuries the use of privat nurses except in critical illnesses, going to a hospital for a rest or observation period, or calling a doctor to a home when the doctor's advice could be obtained by telephone.—Los Angeles *Times*, January 24.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (42)

Alameda County (2)
Bannow, Robert W., *Oakland*
Higgins, Charles Paul, *Oakland*

Contra Costa County (1)
Huston, James M., *Martinez*

Fresno County (1)
Sanders, Jewell M., *Ahwahnee*

Los Angeles County (18)
Andrews, Henry James, *Los Angeles*
Arcadi, Vittorio G., *Los Angeles*
Barnard, Ruth Irene, *Beverly Hills*
Fallon, Madeleine, *Los Angeles*
Fanson, Ethel, *Pasadena*
Fink, David Harold, *Beverly Hills*
Frick, William Oliver, *Los Angeles*
Gronhovd, Gilbert Otto, *Covina*
Harms, George Melvin, *Santa Monica*
Hollands, Robert Arthur, *Pasadena*
Jackson, Josephine A., *Pasadena*
Pearson, August A., *Los Angeles*
Reed, Paul H., *Los Angeles*
Scheffel, Alfred G., *Los Angeles*
Sherman, Max A., *Los Angeles*
Smith, Kendrick A., *Los Angeles*
Straus, Reuben, *Los Angeles*
Ehrke, Albert A., *Compton*

Riverside County (2)
Pierce, Michael Jerome, *Indio*
Ryden, Frank Alfred, *Riverside*

Sacramento County (2)
Hemmiger, G. W., *Sacramento*
Kelsey, Thomas W., *Sacramento*

San Diego County (6)
Bostwick, Jark R., *San Diego*
Fairchild, L. H., *Carlsbad*
Leland, H. G., *La Mesa*
Miller, Edward A., *Coronado*
Pollock, J. V., *San Diego*
Ravin, Oscar G., *San Diego*

San Francisco County (4)
Brainerd, Henry Dean, *San Francisco*
Fender, Frederick A., *San Francisco*
Hosmer, Elizabeth P., *San Francisco*
Pennes, A. E., *San Francisco*

San Mateo County (2)
Ladd, Arthur C., *San Francisco*
Wilson, Jean, *San Mateo*

Shasta County (1)
Bursell, Harold Arvid, *Project City*

Solano County (2)
Clark, John Neal, *Vallejo*
Osnes, E. N., *Vallejo*

Tulare County (1)
Dunn, R. H., *Cutler*

Transfers (11)

Atwood, A. C., from San Luis Obispo County to Solano County

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Clayton, James O., from San Diego County to Los Angeles County
Hill, Jack C., from Riverside County to Santa Clara County
Kamins, Maurice L., from San Francisco County to Los Angeles County
Kruse, Frieda L., from San Francisco County to San Luis Obispo County
McGregor, Mar W., from Santa Barbara County to San Francisco County
Palomaque, E. J., from Los Angeles County to Fresno County
Peters, Lindsay, from Alameda County to San Luis Obispo County
Stafford, Henry E., from Alameda County to Solano County
Stewart, Robert A., from San Francisco County to Alameda County
Williams, Allen N., from Santa Barbara County to San Mateo County

Retired Members (9)

Ashcroft, Felix E., *San Diego County*
Forbes, Harvey J., *Los Angeles County*
French, J. Rollin, *Los Angeles County*
Lazelle, Horace G., *San Diego County*
Lockwood, Myrtle Spencer, *San Diego County*
Mace, Lewis Sayre, *San Francisco County*
McCarthy, H. L., *Los Angeles County*
Sisson, Charles E., *Los Angeles County*
Smith, A. M., *Alameda County*

Life Members (1)

Blevins, W. J., *Yolo County*

Resignations (5)

Dutton, Adena C., *San Francisco County*
Franklin, Milton, *Alameda County*
Heringhi, Winifred, *San Francisco County*
Herring, James B., *San Francisco County*
Smith, Arthur Montell, *Alameda County*

In Memoriam

Boyer, John Ira. Died at Long Beach, February 21, 1943, age 56. Graduate of the College of Physicians and Surgeons, Los Angeles, 1912. Licensed in California in 1912. Doctor Boyer was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Caldwell, Jay Henry. (First Lieutenant, U.S.A.) Died at Santa Maria, February 27, 1943, age 33. Graduate of the College of Medical Evangelists, Loma Linda, 1941. Licensed in California in 1941. Doctor Caldwell was a member of the Los Angeles County Medical Association, and the California Medical Association.

✤

Charlesworth, Irving Eugene. Died at San Francisco, February 28, 1943, age 66. Graduate of the Medico-Chirurgical College of Philadelphia, Pennsylvania, 1906. Licensed in California in 1920. Doctor Charlesworth was a member of the Napa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Gumpert, Maurice William. Died at Hollywood, February 24, 1943, age 42. Graduate of the University of California Medical School, 1930. Licensed in California in 1930. Doctor Gumpert was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Jones, J. Leon. Died at Los Angeles, January 4, 1943, age 59. Graduate of the University of Wooster, Medical Department, Cleveland, Ohio, 1910. Licensed in California in 1922. Doctor Jones was a member of the Los Angeles County Medical Association, and the California Medical Association.

✤

Markel, Howard Hill. Died at San Francisco, February 13, 1943, age 64. Graduate of the University of California Medical School, 1911. Licensed in California in 1911. Doctor Markel was a member of the San Francisco Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Mathewson, Carleton. Died at Fresno, March 1, 1943, age 67. Graduate of the Cooper Medical College, San Francisco, 1900. Licensed in California in 1900. Doctor Mathewson was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Risley, Edward Henry. Died at Loma Linda, February 7, 1943, age 61. Graduate of the American Medical Missionary College, Chicago, Illinois, 1904. Licensed in California in 1911. Doctor Risley was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Rogers, Sherman. Died at Tulare, February 18, 1943, age 52. Graduate of the College of Physicians and Surgeons, Los Angeles, 1917. Licensed in California in 1917. Doctor Rogers was a member of the Tulare County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✤

Snyder, Alonzo DeMoines. Died at Walnut Park, February 16, 1943, age 72. Graduate of the Kentucky School of Medicine, Louisville, 1897. Licensed in California in 1914. Doctor Snyder was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

Edward Henry Risley, M. D.
1881—1943

Edward H. Risley, M. D., Dean of the College of Medical Evangelists since 1924, and a member of its Faculty as Professor of Chemistry since 1911, died at his home in Loma Linda, California, on February 7, 1943, from a cerebral hemorrhage.

Doctor Risley was born at East Ross, Michigan, on September 7, 1881. He graduated from the American Medical Missionary College at Battle Creek, Michigan, and Chicago, Illinois, in 1904. Most of his professional work following his graduation was in the field of chemistry and for a number of years he assisted in teaching that subject at the American Medical Missionary College. Additional work at Yale University, in association with Doctors Mendle and Chittenden, resulted in an offer to a teaching appointment on the faculty of that medical school, which he declined in favor of continuing

his work at Battle Creek.

He was instrumental in establishing clinical and research laboratories in the field of chemistry at Battle Creek where he did some of the preliminary analytical work for the W. K. Kellogg Food Company.

Doctor Risley was co-author of three books, namely, "The Food Question," "Foods, Nutrition and Clinical Dietetics," and "Home Physician and Guide to Health."

Doctor Risley maintained a very strict discipline for himself and was very tolerant with others. He was serious-minded, honest, and a firm believer in the influence of a consistent life based upon high Christian ideals. He was keenly interested in progress and was never more happy than when taking part in some new enterprise or observing the results of his labors. He maintained an active interest in the profession of medicine and was serving his second term as President of the San Bernardino County Medical Association at the time of his death.

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Howard H. Markel

1879—1943

The crippled children of California lost a cherished friend and benefactor when, on February thirteenth, death took from our midst, a respected colleague, Howard Hill Markel. A surgeon of "the old school," he will be sorely missed, and his memory perpetuated in the hearts of countless grateful patients from Bakersfield to Eureka, and parts of the world as far distant as China. His path to success was rough and beset with hurdles, but his tireless energy, his active mind and everlasting unselfishness brought a just reward.

Born in Davis, Illinois, November 3rd, 1879, he lived there until moving to Monroe, Wisconsin, where he attended high school.

Graduating from the Medical School of the University of California in 1911, Howard Markel was an indefatigable worker on the staff of his Alma Mater, first in a resident capacity, later in the out-patient department.

He probably did as much if not more charity surgery on those in need than anyone in California. He was an early exponent and friend of scientifically-applied physical therapy in orthopedics, and an outspoken foe of pose, pomp and politics. He was unusually kind to any young practitioner fortunate enough to come under his wing—in or out of his own specialty.

Yes, he had his faults, like all of us; the two biggest ones were generosity and abiding faith in his fellow-man. These cost him a fortune and short-lived criticism, but never embittered him. His deep, understanding tolerance arose from a life of hard work. Four years ago a thrombus of the left leg necessitated amputation. This, however, did not prevent him from carrying on as usual, and although the leg was often very painful from standing long hours over the operating table, he never complained.

Three years ago, while on a trip to Florida, he suffered his first heart attack. There was no recurrence of this until last December, and he was up and about, confidently looking forward to a return to work when, on February 13th, he slipped quietly away at his home.

Hippocrates and his pupils believed that the arteries transported air to keep the internal fires burning.

Soupfin shark, now our richest source of vitamin A, was once used as fertilizer and sold for as little as $10 a ton.

Alfalfa contains large quantities of vitamin K.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

President's Report

To the Members of the Woman's Auxiliary:

When the Woman's Auxiliary to the California Medical Association convenes for the annual State Meeting, members will see a 1943 streamlined session. All activities will be geared to the times, taking care of a maximum amount of business in a minimum amount of time. Headquarters will be at the Biltmore Hotel. Because of the accessibility of this location it is hoped that as many as possible will try to attend. Being a two-day meeting it will be possible for many to plan ahead for it. These are critical times, with many fronts to be protected. Now, as never before we should be aware of our responsibility to the Medical Profession. With so many of our men away in the Service, it quite behooves us to carry on for them as well as for those who are working on the Home Front.

Registration will be on Saturday, May 1st, from 2:00 p.m. until 6:00 p.m. and from 7:00 p.m. until 9:00 p.m. At this time it is hoped that reservations for the luncheons on Sunday and Monday will be made. The General Business meeting will be held on Sunday, May 2nd, from 9:30 a.m. until 1:00 p.m. At 1:30 there will be a luncheon honoring Mrs. F. G. Lindemulder, retiring President, and Mrs. Charles C. Landis, President-Elect. The President's Ball will take place on Sunday evening in the Biltmore Bowl. On Monday morning, May 3rd the post-Convention board meeting will be held. Those not attending this will have the time to do with as they please. At 1:00 o'clock, however, there will be a luncheon and fashion show at Bullock's Wilshire which everyone should attend. It is of the greatest importance that reservations be made for the luncheons.

Respectfully submitted.
MRS. F. G. LINDEMULDER, *President.*

County Auxiliary News Items

For some time women of the Los Angeles County Medical Auxiliary have been coming together to do Red Cross work. Now they are pleased to have their own Red Cross unit, meeting twice a week in the Los Angeles County Medical Society Building. On Friday, February 12, an open house was held to show what is being done.

Another project of this Auxiliary was the furnishing of four day-rooms at Camp Santa Anita. This work was accomplished through contributions of furnishings and cash by members.

William R. Molony, Sr., M.D., President of the California Medical Association, and Mr. Manuel Aguilar were guests of honor at the January meeting. Mrs. Franklin Farman presided at the meeting, which was held at the Mona Lisa Restaurant.

"Are all Mexican Boys 'Pachucos'?" was the subject of a talk by Stephen J. Keating, Assistant Director of Coördinating Councils of the Los Angeles County Probation Department. Mrs. Elmer Belt spoke on the work of the U.S.O. with troops in transit, as hospitality group in the Union station.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

The San Benito County Auxiliary, with a membership of only six, sponsored a dancing party in San Juan, which netted them $495.60. This money was used to furnish a room in the Hazel Hawkins Hospital, Hollister, to be used by the Red Cross.

Mrs. Wayne Templeton presided at the February meeting of the Riverside Medical Auxiliary, which was held at the Riverside Community Hospital. The ten members present discussed means and ways of presenting to the public the necessity of fighting cancer, with knowledge and the importance of working as an Auxiliary on the membership drive of the American Society for the Control of Cancer. Mrs. Hugh Felps led the discussion.

The evening was spent in rolling bandages for the hospital. Plans were made for the annual spring tea.

Fifteen members of the Auxiliary with Mrs. Thuresson as leader, are working on the 1943 Riverside County Red Cross War Fund drive.

The regular meeting of the Woman's Auxiliary to the Sacramento Society for Medical Improvement was held at the home of Mrs. Lorenz Ruddy, on February 16.

A program, featuring Mrs. Robert Mumm in a pianologue, concluded the meeting. Hostesses were Mrs. Edgar Haag, Mrs. James Coyle, and Mrs. John L. Fanning.

Hospitality House is the main project of the Alameda County Auxiliary, and, in spite of food rationing, donations of food by members have been very generous.

This year, instead of the annual bridge party which is usually given in March for the Philanthropic Fund, district teas and neighborhood luncheons have been planned for this purpose by various members.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (December)		39,000
Rural Health Program		5,100
War Housing Projects (February 1) (Approximate)		32,000
Vallejo	10,000	
Marin	5,000	
Los Angeles	7,000	
San Diego	10,000	

California Physicians' Service has found the going difficult during the past four years. We believe that most of the faults have now been corrected. Physicians will be interested in a brief report of C.P.S. activities because of their effect on the medical professional throughout the State.

C.P.S. started operations in 1939 with a full coverage contract. We have found that this type of contract was difficult to administer, and that under it the plan has been subjected to excessive use of service by a minority of beneficiary members, with the end result that the doctors received very little for their services. In the summer of 1942, we developed a much simpler two-visit deductible plan, and have already converted approximately 80 per cent of the full coverage contracts to the new plan. The remaining members will be converted within the next two or three months.

This new plan has corrected many of the defects of the old plan, and has eliminated most of the complaints and problems of doctors and beneficiary members. Since the start of this conversion program in September of 1942, the unit value has increased 36 per cent, and we confidently expect further betterment. The conversion to date has been accomplished without any significant loss of membership.

In the new two-visit deductible plan, the physician is to charge the member his usual fee for the first two visits, just as if he were a private patient. If x-ray, laboratory tests or surgical operations are necessary during the first or second visit, their cost will be paid from the C.P.S. fund. Continued treatments beyond two visits and beginning with the third visit will be payable from the C.P.S. fund.

Our enrollment efforts are concentrated upon this two-visit deductible plan and upon the surgical plan, and we are pointing our efforts directly to the "lower income groups"—that is, where family incomes do not exceed $3,000 per year.

Electron Microscope.—Electricity that has been "freed from the bondage of wire transmission" is being used by General Electric engineers to study minute specimen invisible under the ordinary light microscope. This electricity, in the form of electrons, is shot from a small electron gun at a fluorescent screen 11 inches away, and similar to that used in a television set. The specimen is inserted between gun and screen and as the electrons pass through or around it, and are magnified, they form an image of the specimen on the screen.

This action takes place in a simplified electron microscope described by Dr. C. H Bachman in a talk January 23, at Columbia University (New York), before a joint meeting of the American Physical Society and the American Society for X-Ray and Electron Diffraction.

The instrument, which can be plugged into the regular 110-volt a-c house circuit, is capable of producing images 10 000 times the size of the subject. Further enlargement of the picture can be made photographically up to 100 000 times the size of the original specimen, or better, if desired. . . .

The new microscope has an over-all height of 52 inches, and requires floor space of about two by three feet. The cabinet includes the simple power supply, the mechanical vacuum pump, and an air-cooled, oil-diffusion high vacuum pump. A camera is provided for mounting on the front of the instrument for photographing reproduction when this feature is desired The cabinet is mounted on castors for mobility, and weighs 600 pounds. No special facilities for operating the instrument are needed, and the unit includes the microscope proper and all auxiliaries.

Physically, the microscope has been designed for the convenience of the operator. The electron chamber is mounted horizontally, the eye piece at one end being at eye level for an operator seated before the instrument. The electron chamber is supplied with voltage and is evacuated from the end which extends into the cabinet. All controls are at the operator's fingertips. These include accelerating voltage, image intensity, the main vacuum valve, focus control, and the movement of the specimen. In effect, the operator is seated at a desk with a drawer beneath so that materials and notebooks are conveniently at hand.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association, Hotel Biltmore, Los Angeles, on Sunday, May 2—Monday, May 3, 1943.

Very Important. Purchase railroad transportation today. Also make hotel reservations (with Hotel).

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a. m., under the title "Your Doctor and You."

In April, KFAC will present these broadcasts on the following Saturdays: April 3, 10, 17, and 24.

The Saturday broadcasts of KECA are given at 10:45 a. m., under the title "The Road of Health."

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *New Journals:* From the Brooklyn Medical Press comes *Experimental Medicine and Surgery,* with international editing including J. J. Izquierdo of Mexico, and C. J. Wiggers tight review on the Irreversibility characteristic of shock (1:1, 1943), and an interesting series on procaine esterase, by B. Kisch, et al (1:51-93, 1943). The first number of *Gastroenterology* is dedicated to Wm. Beaumont and contains R. Elman's correlation of cytological and chemical changes in the liver (1:24, 1943). Watch for *Texas Reports on Biology and Medicine,* which will go free to every medical institution library wanting it. First issue will have notes by Cary, Ebaugh, Mira, Gregory, Anigstein and Carlson.

2. *And New Books:* E. M. East continues studies on *Biology in Human Affairs* (McGraw, New York, 1943). J. C. Berry describes *A Pioneer Doctor in Old Japan* (Revell, New York, 1942). W. F. Boos gallops along *The Poison Trail* (New York, 1942). E. Weiss and O. English offer *Psychosomatic Medicine* (Saunders, Philadelphia, 1943). W. R. Cooke's *Essentials of Gynecology* (Philadelphia, 1943), is swell except for no stimulus to further reading. V. Nesfield discusses *Viscosity of Blood and Its Bearing on High Blood Pressures* (Muller, London, 1942). A. S. Pearse gives a neat *Introduction to Parasitology* (C. C. Thomas, Springfield, Ill., 1942).

3. *Psychiatry Clinics:* The Langley Porter Clinic at the University of California Medical Center, San Francisco, was dedicated with excellent remarks by Walter Treadway, Langley Porter, Karl Bowman, et al. Its Out-Patient Department is named in honor of Aaron Rosanoff, who started it. The proceedings should be published. The Menninger Clinic in Topeka, Kansas, steps out with a neat gynecology and obstetrics number of its *Bulletin* (free on request). It also supports a monograph series of which D. Rapaport's *Emotions and Memory* is No. 2. Further, Karl Menninger's *Love Against Hate* (New York, 1942), is what we need more of.

4. *Chemotherapy:* New diamidino compound, 4:4'diamidino-diphenoxy-propane dihydrochloride (Propamidine), is found very useful in treating acute and chronic septic wounds, and seems almost ideal for first aid in burns (W. Thrower and F. Valentine; A. McIndoe and A. Tilley; G. Mosley and J. Bentley, *Lancet* 1:133-138, January 30, 1943). H. J. Barber, et al, note four fold rise in toxicity of stilbamidine solutions (used in kala azar, I. Napier, *Ind. Med. Gaz.,* 77:321, 1942), on exposure to light (*Nature,* 151:107, January 23, 1943). M. Ehrenstein well summarizes antimalarials (*Amer. J. Pharmacy,* 114:456, 1942). W. Trager's item on reducing malaria susceptability by biotin appeared in *Science* (97:206, February 26, 1943).

5. *Liver:* Pleasant to see J. M. Munoz and L. F. Leloir's note from Buenos Aires on fatty oxidation by liver enzymes (*J. Biol. Chem.,* 147:355, 1943). L. L. Chaikoff,

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

K. B. Eichorn, C. L. Connor show that prolonged feeding of a high fat diet may produce fatty infiltration and liver cirrhosis (*Amer. J. Path.*, 19:9, 1943). M. M. Wintrobe, et al, say that pyridoxine deficiency causes anemia, convulsions and fatty liver (*Bull.*, Johns Hopkins Hosp., 72:1, 1943).

6. *Elements:* M. E. Reid well reviews interrelations of calcium and ascorbic acid to cell surfaces, intracellular substances and physiological action (*Physiol. Rev.*, 23:76, 1943). S. Spiegelman and J. M. Reiner offer important kinetic analysis of potassium accumulation and sodium exclusion in cells (*Growth*, 6:367, 1942). G. E. Sheline, I. L. Chaikoff, H. B. Jones, M. L. Montgomery find that zinc is mostly excreted by gastroenteric tract (*J. Biol. Chem.*, 147:409, 1943).

7. *In General:* V. Menkin isolates factor in euglobulin factor (necrosin) responsible for tissue injury in inflammation (*Science*, 97:165, February 12, 1943). D. Nelson, S. Goetzl, S. Robins, A. C. Ivy confirm J. A. Campbell (*Quart. J. Exp. Physiol.*, 28:231, 1938), that high carrot diet protects rats from lethal effects of low oxygen pressure (*Proc. Soc. Exp. Biol. Med.*, 52:1, 1943). E. E. Nelson describes pressor response to acetaldehyde (*Ibid.*, p. 23). M. E. Stevens, et al, discuss expectorant action of creosote and guaiacols (*Canad. Med. Asso. J.*, 48:124, 1943). R. R. Burtner finally publishes account of aryl acetic acid ester antispasmodics reported by G. Lehman and P. K. Knoefel (*J. Pharmacol.*, 74:217, 274, 1942; *J. Amer. Chem. Soc.*, 65:262, 1943). C. H. Sawyer says cholin esterase content is index of functional capacity of neuromuscular apparatus (*J. Exp. Zool.*, 92:1, 1943).

Lane Popular Medical Lectures.—The Stanford University School of Medicine announces the sixty-first course of popular medical lectures (illustrated). The addresses will be given at Lane Hall, north side of Sacramento Street, near Webster, on Friday evenings: April 2, April 16, April 30, and May 14, 1943, at eight o'clock sharp.

Program follows:

Friday evening, April 2, 1943: "Food Rationing and Civilian Health," J. C. Geiger, M. D.

Friday evening, April 16, 1943: "Tropical Diseases Menace United States at War," Alfred C. Reed, M. D.

Friday evening, April 30, 1943: "Health Service to the Public during the Emergency," Loren R. Chandler, M. D.

Friday evening, May 14, 1943: "Protection of Health and Fitness in Flying Personnel," John K. Lewis, M. D.

All interested are cordially invited to attend.

Mailing Journals Abroad.—Recent rulings of the Office of War Censorship, a division of the Board of Economic Warfare, make it necessary to secure a special export license for the mailing of publications to any foreign country. Publishers may secure such licenses for original mailings, but individuals who wish to send medical journals abroad will find it difficult to get the necessary permission.

Several cases have arisen where copies of California and Western Medicine have been addressed by individuals to addressees in foreign countries and the magazines have been held up or removed from the mails because of the lack of a license. If individuals wish to maintain journal exchange agreements with people in foreign countries, communicate with the C.M.A. office for information on the steps required to obtain an export license.

California Tuberculosis Association: Annual Meeting Changed to Meet at Fresno.—Fresno was designated by the Board of Directors of the California Tuberculosis Association as the meeting place for the Annual Meeting. The change in place was made necessary on account of war restrictions, particularly the housing shortage and crowded hotels in San Francisco where the meeting had originally been scheduled to take place.

The meeting opened at 9 a.m. on Wednesday, April 7, and the last session closed at 5 p.m. on Thursday.

All nonessential or purely social events were deleted from the program, which had been streamlined to fill every hour of the two-day session with important and vital sessions.

Clinical Section: The usual x-ray symposia were held. The time: Wednesday, April 7.

Trudeau Society Meeting: The annual meeting and election of officers of the California Trudeau Society was held at 7 p.m. on Wednesday, April 7.

California Conference of Tuberculosis Secretaries: The annual meeting and election of officers convened at 7 p.m. on Wednesday, April 7.

Delegates' Meeting: The annual meeting of the Delegates, California Tuberculosis Association, took place from 1 to 3 p. m. on Thursday, April 8.

Legal Responsibilities of Physicians Regarding Death Certificates.—The following communication has been received:

"Attention of physicians is directed to Section 10401 of the Health and Safety Code, which specifies:

"The physician shall within 15 hours after the death deposit the certificate at the place of death, or deliver it to the attending funeral director at his place of business or at the office of the physician.

"A minority of physicians are causing funeral directors to make repeated trips to obtain death certificates. Since rubber, gasoline and time are very valuable now, it is pointed out that the physician has a legal responsibility to supply the death certificate promptly and that compliance with the law is assistance to the war effort."

Wartime Industrial Health.—A reprint, from California and Western Medicine, Vol. 57, No. 4, October, 1942—pp. 233-244, and presenting a symposium of addresses—in full or in abstract—given at Institutes on Wartime Industrial Health, held in the cities of San Francisco, Crockett, Oakland, San Diego, Inglewood, Glendale and Huntington Park, on August 18-28, 1942, has been sent out by the Western Section of Industrial Surgeons and Physicians (Rutherford T. Johnstone, 423 Towne Avenue, Los Angeles, Secretary). The Institutes were sponsored by the California State Board of Public Health, California Medical Association, and Western Association of Industrial Physicians and Surgeons.

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in California and Western Medicine (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50; and February, pp. 92-93. More recent excerpts follow:

Living Up to Tradition

The medical profession hasn't done a lot of talking about making the "sacrifices" its members are making. And yet doctors, perhaps more than any other group next to the service men, are making real sacrifices in this war.

Thousands of them have voluntarily given up their practices. They live in the foxholes with the soldiers. They fight and die with the navy and the marines. They perform miracles amid blood and suffering. Gone is the business for which they spent so many years in preparation, often on a financial shoestring.

The doctors left at home are making sacrifices too. Men who should be enjoying the leisurely aftermath of useful careers are back in harness working at a killing pace. They are on duty 24 hours a day—and they don't yell for time-and-a-half when Mrs. Jones is having a baby at 3 a.m.

The doctors are carrying out the tradition of American medicine in every emergency. Their example might well be followed by workers in other fields.—Isleton *Journal*, February 19.

* * *

Match This Record

More than 28 000 physicians volunteered their services without pay to the Selective Service boards. More than 40 000 physicians gave up their careers in civilian practice to serve with the armed forces. The directing board of the Procurement and Assignment Service for Physicians, and its many representatives throughout the nation, serve without one cent of remuneration. The hundreds of physicians on the consultant committee of the Division of Medical Science of the National Research Council, and in the office of Research and Development, contribute time and income without remuneration. Throughout the nation, thousands of doctors furnish countless services in connection with civilian defense, without pay. It would be interesting to know what other trade or profession can match this record of public service.

And yet proposals are made to throw American medicine into the political arena, and level it off to the standards prevailing in European nations where experiments in socialized medicine have utterly failed to produce the health records and benefits to the general public which are the rule, rather than the exception, in the United States. Fortunately for the people of this country, such efforts seem to have failed.

American medicine is marching ahead unselfishly and scientifically in its determination to maintain for our armed forces and the people at home the highest medical standards in the world—not for this year, or the next, but for every year.—Santa Clara *News*, January 29.

* * *

Danger of Epidemics

With so many physicians in the armed services, every individual should do everything possible to conserve health and build up resistance against disease. We know of one recent instance where a doctor made seventy-two residence calls in one day. One of those calls saved the life of a baby. Another reason for the necessity of conserving health is the shortage of food supplies. The housewife must exercise extreme care in buying things at the grocery that will build up health. Even milk is being rationed, but growing children must be supplied with this vital necessity. The doctors and health authorities deserve, and should receive, the fullest coöperation. In the last World War, more Americans lost their lives in the influenza epidemic than in battle casualties We must be prepared against epidemics.

Guard Your Health

Another way you can help to win the war, according to Dr. Frank H. Lahey of the War Manpower Commission, is to guard your health with redoubled vigilance. Every day you are forced to stay away from work, due to illness, contributes to the problem of absenteeism and slows down production, says Dr. Lahey. And every time you call the doctor, needlessly, you put an added load on the Nation's limited supply of medical manpower.

The War Manpower Commission reports that approximately 10,000 more of the Nation's 180 000 physicians will be called into military service during the present year, which will leave about 80 000 doctors for civilians. This supply, if properly distributed and allocated, is adequate to care for the needs of the civil population, says Dr. Lahey, "if civilians will take every possible precaution to keep well." But with more than half the normal supply of doctors serving in the armed forces, it is vital that the public health be maintained at a high level.

Sneeze at Hitler, if you must, is the purport of the government's warning. But do it figuratively, not literally. Keep the home front healthy!—Red Bluff *News*, February 3.

* * *

Physicians Need Coöperation Now

With thousands of American doctors being called into the armed services, added burdens are being placed upon those still serving the home front. This is why the civilian is being asked to do his part so that adequate medical care will be assured everyone.

Five suggestions handed down by the War Manpower Commission bear directly on the subject:

1. Keep healthy. Get plenty of sleep, eat the proper foods and get plenty of fresh air, exercise and recreation.

2. Avoid unnecessary demands on the physician's time whenever possible; go to his office during office hours instead of asking him to call upon you at your home.

3. In case of really serious illness, do not delay in calling your doctor or calling at his office. It will save his time if he is called promptly in any case of acute illness. This is not a contradiction of Point 2. It does, however, assume the average citizen has good judgment. In doubtful cases, call the doctor at once.

4. Avail yourself of opportunities to study first aid so as to know how to give care to the injured until such time as a doctor can take over.

5. In connection with Point 1, if you do not know the basic rules of nutrition, avail yourself of opportunities to learn the facts.—Sacramento *Bee*, February 17.

* * *

Physicians Were Ready

American doctors have been criticized for bungling the medical manpower problem. The incongruity of the criticism is apparent when it is realized that it comes from the same sources that have at least helped to bungle manpower in every activity. The food problem is becoming critical, due largely to lack of manpower; transportation, mining, manufacturing, processing and distribution are all seriously handicapped by the manpower jumble. And in none of these undertakings have the needs of the military drawn as heavily on manpower as in the field of medicine.

It is a dead certainty that if the medical men had been no better prepared for war than those who criticize them so loudly the medical situation would indeed be serious. Long before there was much thought of war coming to this country, the doctors were mobilizing their resources. When war came they knew almost to a man the number of doctors available to the home and military

fronts. They met the requirements of the military front. They are now meeting the requirements of the home front.

Admittedly, there has been hardship in some areas. Emergencies have arisen. Tempers have been frayed. But the background of American medicine has given it tools to do the job. That background is freedom; the tools are the same tools that enable American industry to outproduce the world in twelve months. They are tools of competence, integrity, and faith—faith in the ideals of individual opportunity that have made this the greatest Nation on earth.—Isleton *Delta News,* February 12.

* * *

Illness Is Part of Fifth Column

Because a healthy home front is so vital to America's wartime effort one should be more vitamin conscious than ever before. Health authorities advise you should get plenty of exercise, too, and not forget your eight hours sleep. It will go a long way toward keeping you in the pink of condition, but there is much more to it than that. You all know about the fifth column of Axis inspired saboteurs—destroying plants—impairing production. Well, illness is part of that fifth column and it is just as dangerous as any Nazi because it sabotages production by the loss of man hours and holds up supplies so vitally needed.

It is the No. 1 job of every woman on the home front to fight that sabotage—to keep herself and her family well and to know how to cope with minor ailments.

Learn home first aid now, remember your best weapon against illness is medical knowledge. Learn how to take care of colds, properly, treat bruises. One cannot afford to depend on hunches or cure alls. Home first aid will teach you how to treat minor ailments scientifically and efficiently. The right treatment in time will keep both you and your family working on the home front.

Because doctors and nurses are needed by boys in the armed forces, you must do everything you possibly can to keep yourself well without their aid—especially for minor ailments. By learning home first aid and keeping healthy, you are doing your share for victory. Home first aid is knowledge every woman should have because it is invaluable in peacetime as well. An ounce of prevention is worth a pound of cure. Keep the home front healthy—for victory.—Sacramento *Bee,* February 17.

* * *

Physicians in Wartime

One of the busiest professions in the country today, the medical one, is establishing a high record in the amount of volunteer service rendered.

To Selective Service boards alone, more than 28,000 physicians are giving their services without pay, and more than 40,000 gave up their careers in civilian practice to serve with the armed forces.

The directive board of the Procurement and Assignment Service for Physicians, and its many representatives throughout the Nation, serve without one cent of remuneration. In addition, there are hundreds of physicians on the consultant committee of the Division of Medical Science of the National Research Development. These also contribute their time to the cause. Thousands of doctors are furnishing countless services in connection with civilian defense.

As for the physicians at home, there are no limits save physical exhaustion to their hours on duty. Generally, we believe, the public is aware of the strain put upon the medical profession, and is willing to assist it by avoiding unnecessary calls and demands. Maintenance for our armed forces and the people at home of the highest medical standards in the world is a big job that is being carried on at considerable sacrifice.—Oakland *Tribune,* February 21.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Honor to George Dock, M.D.: Recipient of "The Gold-Headed Cane"

Signal honor has come to Dr. George Dock, 397 East Calaveras Street, Pasadena, who now is proud possessor of the famous "Gold-Headed Cane," in replica, presented by the University of California Medical School.

"The Gold-Headed Cane" was carried by the great British physician, Dr. John Radcliffe and was bequeathed down the years to Drs. Mead, Askew, Pitcairn and Baillie, all famous names in Great Britain's medical history. It now is being preserved by the Royal College of Physicians in London.

University of California four years ago conceived the idea of reproducing "The Gold-Headed Cane" once yearly and, by means of a careful selective system, presents it to the outstanding student of the graduating class.

This year Dr. Dock, of Pasadena, was asked to make the presentation speech.

"I was completely surprised and pleased when I received, along with the outstanding student, a duplicate cane," said the physician, of whom Sir William Osler, Britain's greatest surgeon, referred to in one of his books as "the greatest medical man of the day."

"In the early days of medicine," continued Dr. Dock, "it was customary for physicians to carry a cane, the handle of which was fitted with knobs of aromatic herbs. He sniffed the cane when handling contagious disease cases."

The cane once was considered as the badge of a physician, in the same manner that the sword was the mark of an Army officer.

Dr. Radcliffe, in addition to his fame as the greatest man of medicine at the start of the 18th century, was extremely wealthy. Besides his cane, he bequeathed funds for the Radcliffe Hospital, the Radcliffe Library and the Radcliffe Observatory, at Oxford University.

In his address to the medical students during the cane presentation ceremonies, Dr. Dock reviewed the life work of another great physician, Dr. M. Howard Russell, a classmate of his Philadelphia medical school days and nephew of a Civil War Abolitionist and reformer. In his address he appealed to the students, in their professional lives ahead, "to regard their patients as human beings, not merely cases."

Dr. Dock was born in Hopewell, Pa., on April 1, 1860. He received his medical degree in the University of Pennsylvania in 1884. In 1895, because of achievements in the medical field, Harvard University conferred an honorary A. M. degree on the physician, and in 1904, the University of Pennsylvania conferred upon him the degree of Sc.D. Another degree, that of LL.D., came from the University of Southern California in 1936. He served as professor in various branches of the study of medicine at the Texas Medical College, University of Michigan, Tulane University, Washington University Medical School and U. S. C.

Dr. Dock came to Pasadena 20 years ago, and his home in Altadena is one of rare beauty, especially as to its landscaping. The physician's hobby is birds. He has a fine collection of parakeets and canaries in outdoor cages and natural setting.

In 1916 and 1917 he was president of the Association of American Physicians. In Pasadena he has been a member of the Valley Hunt Club for many years. His son, George, former faculty member in the medical schools of the University of California and Cornell University, is a major in the U. S. Army Medical Corps.—Pasadena *Star-News,* February 20, 1943.

WMC 'Doing Everything It Can to Defer Fathers'

Washington, March 4.—War Manpower Commission Chairman Paul V. McNutt said today that everything possible is being done to delay as long as practicable the drafting of fathers and that the order prohibiting the drafting of pre-Pearl Harbor family men still is in effect. . . .

He said that the order in which registrants are called for military service is and will be:

1. Single men with no dependents—1-A.

2. Single men who do not contribute to the war effort but who have dependents—3-A.

3. Single men with dependents and who contribute to the war effort—3-B.

4. Men who are not engaged in the war effort but who maintain a bona fide family relationship with wife only—3-A.

5. Men who are engaged in the war effort and who maintain a bona fide relationship with wife only—3-B.

6. Men who are not engaged in the war effort and who

maintain a bona fide relationship with wife and children or children only—3-A.

7. Men who are engaged in the war effort and who maintain a bona fide relationship with wife and children or children only—3-B.

The recent list of occupations for which deferments will not be given, regardless of dependency, becomes effective April 1. The order effects only those aged 18 through 37.—San Francisco *News*, March 4.

50,000 Nurses Needed for Possible Million Wounded

Chicago, February 13.—(AP.)—It soon may be necessary to ration nurses and to convert dude ranches and other vacation resorts into infirmaries, the American Hospital Association was informed today.

James A. Hamilton, president of the organization, reported nurses would have to be rationed unless there was a substantial increase in the number trained by nursing schools. He estimated 50,000 new nurses would be needed to assure adequate care for patients.

May Reach Million

Maury Maverick, director of Governmental division of the War Production Board, stated treatment of sick civilians and casualties from the war zones would make it necessary to use all available hospital space and all kinds of buildings that can be adapted to such use—including "seaside resorts, mountain homes, dude ranches, office buildings, spas, fishing lodges, factories, ski lodges." He predicted the number of war wounded may rise as high as 1,000,000, and recommended an immediate national survey to find quarters.

Miss Alma C. Haupt, executive secretary of a nursing subcommittee of the Defense Health and Welfare Service in Washington, figured 61,000 nurses would be needed for the armed forces this year and that 290,000 would be required for all types of civilian nursing—a total of 351,000. She predicted only 275,000 would be available by next October, and that the result would be a shortage of 76,000.

Hamilton, director of the New Haven, Conn., hospital, said any rationing program for nurses would have to be controlled by the War Manpower Commission and that it would affect home, hospital, public health, institutional and factory nursing. He suggested that men and women train for volunteer hospital service.

He and the others expressed their views at the Association's mid-year conference.—Los Angeles *Examiner*, February 14.

Accident Rate Shows Decline

Casualties Still Top Battle Loss

Chicago, February 4.—(UP.)—The home-front casualty list of 93,000 killed and 9,300,000 injured during America's first year at war far exceeded the total casualties on the battlefronts, the National Safety Council reported today.

But despite its huge casualty tolls, the home front was 8 per cent safer in 1942 than in 1941, the report said.

This saving was attributed to wartime restrictions on speed and travel, which cut traffic deaths by 12,200, or 30 per cent.

The toll of injured, however, remained about the same as for 1941. It meant that 1 out of every 14 persons in the United States suffered injury during the year.

The accidents cost the nation $3,700,000,000 in wage losses, medical expense, insurance and property damage.

In industry alone, the loss of time and material through accidents could have built 22,000 heavy bombers or added 54 working days to the entire shipbuilding and aircraft industries, the council reported.

Falls caused most accidental deaths—24,000—excluding traffic fatalities.

The 1942 traffic toll was the lowest since 1927, with 47 states reporting sharp decreases.

Home accidents accounted for 30,500 deaths, 120,000 permanent disabilities and 4,500,000 injuries.

Sacramento, February 4.—Final figures compiled by the State Motor Vehicle Department disclosed today that 2,670 persons were killed in California traffic accidents during 1942, against 3,615 in 1941.

Officials said the reduced wartime speed limit contributed largely to lowering fatalities.—San Francisco *News*, February 4.

Opening Empty Hospitals to Public, Fought

Scores of wards now closed, with hundreds of idle beds, in the San Francisco Hospital, Laguna Honda Home and Hassler Health Home, should be opened immediately to paying patients of the general public, Pearce Davies, assistant regional director of the Office of Defense, Health and Welfare Services, urged today in a letter to Health Director Geiger.

Dr. Geiger disapproved, on grounds it is illegal to admit other than indigent patients to city-operated hospitals, and "in my opinion any other arrangement for such an institution would be unfair and in competition to private hospitals and an infringement of a governmental agency in the private practice of medicine."

In view of the entry of a Federal agency into the public hospital question in San Francisco, Dr. Geiger said, he has sent copies of Mr. Davies' request, together with his reply, to Mayor Rossi, Chief Admr. Officer Brooks and City Attorney O'Toole, "because of the probable illegality of the plan."

Mr. Brooks, on studying both letters, said he had issued an order to the Health Department to "open all possible hospital space to the armed forces."

This order will meet the situation, he said, by relieving private hospitals of cases of the military, thus relieving additional beds for general civilian use.

'Mayor Has Power'

"So far as the legality of the problem is involved," he said, "I am sure that Mayor Rossi, under his emergency powers, can open public hospitals to any one, but it will not be necessary to place paying private patients in them if offering our wards to the armed forces will alleviate congestion in private hospitals."

Mr. Davies' letter said, in part:

"The population of Bay Area communities has increased out of proportion to the provision of certain community facilities and the demands upon existing private hospitals will be beyond their capacity to serve.

"The stringencies of critical materials and the time required to construct new buildings operate against new construction as an answer to the need.

Inquiry Is Put

"With these facts in mind, we are writing you to learn what steps should be taken to bring to the attention of those charged with administration of the county hospital the desirability of opening the institution to paying patients. . . . As you know, Los Angeles County has found it necessary to waive the showing of financial need as a requirement for admission."

Declaring, in addition to his other objections, "It must be realized San Francisco is a possible area of bombing and our institutions must be prepared for expected casualties in such an event," Dr. Geiger listed wards and beds now vacant as follows:

San Francisco Hospital.—Psychopathic Division: Two empty wards of 52 beds. (At various times these wards have been occupied by psychopathic patients of the Army, under an agreement between the Army and the City and County.) Maternity Division: Three finished wards of 21 beds, two unfinished wards of approximately 66 beds. Tuberculosis Division: Two wards, 70 beds. Isolation Division: One ward, 30 beds. General Hospital: Three wards, two fully equipped, including 105 beds.

Laguna Honda Home.—Main Building: Four wards of 176 beds; old infirmary: Three wards, 144 beds.

Hassler Health Home at Redwod City.—One empty building of two wards, approximately 40 beds.

Shortages Blamed

Shortage in medical, nursing and orderly personnel has made necessary the closing of some of the wards, Dr. Geiger said.

"In the Laguna Honda Home there could be opened, if the finances and staff were available, two wards for occupancy by suitable cases now waiting transfer either from the San Francisco Hospital or from inadequate homes. The personnel shortage would practically make it impossible to open wards at the San Francisco Hospital under present conditions."

The chief stress of Dr. Geiger's statement was upon the traditions and legalities of the question.

"It has been traditional over the years," he wrote, "that the City and County Hospital, specifically the San Francisco Hospital, should serve only the indigent ill. It is staffed, with our approval, by the university Medical Schools of Stanford University and the University of California, and used for teaching purposes.

"No case enters this institution, except in actual emergency, without complete social service investigation for financial eligibility accordingly."

Many patients able to pay for treatment would not be satisfied with public institution food, Dr. Geiger intimated.

"It must also be remembered," he said, "that in such an institution we are on a minimum ration, which the

private patients would not desire, and a change otherwise would be a demoralizing effect upon the present conditions in such an institution."

* * *

Army Confirms Word of Menlo Park Hospital

Reports the Army will construct a hospital on the Timothy Hopkins estate at Menlo Park were confirmed today by Captain E. L. Boldemann, of the Army Engineers' Office, 1441 Van Ness Ave., who announced materials are now being unloaded. The hospital will have 1,700 beds. Building will commence as soon as final plans are approved by the Surgeon General's office in Washington.

The hospital will comprise 65 buildings, all of a semi-permanent nature, Captain Boldemann said.—San Francisco *News*, March 26.

Opposition to Pay Patients in San Francisco Wards

A suggestion by a Government agency that empty wards in the San Francisco County Hospital and other public health institutions be opened to pay patients has been rejected by Dr. J. C. Geiger, city health director, he disclosed yesterday.

The suggestion came from Pearce Davies, assistant regional director of the Office of Defense Health and Welfare Services. He inquired about the possibility of admitting to the San Francisco Hospital not only paying patients, but also patients from surrounding counties.

Dr. Geiger, city health director, pointing out that there were unoccupied wards with a total of 674 beds in the San Francisco Hospital and other city health institutions, replied that San Francisco was a possible bombing area and that the institutions must be prepared to receive casualties in such an event.

He also pointed out that traditionally, the San Francisco Hospital was for indigent sick persons, and that a private arrangement there would be "unfair and in competition to private hospitals and an infringement of a governmental agency in the private practice of medicine.

"Conditions might eventually force a change in the present policy," Dr. Geiger added, "but that time has not yet arrived."

"However," Dr. Geiger pointed out, "these negotiations have not reached fruition at present. The staffing, it has been explained—medical, nursing, orderlies, etc.—must be done by the Navy, because of the shortage in our own staff and the impossibility of obtaining further help."—San Francisco *Examiner*, March 27, 1943.

Concerning a Thieving Male Nurse:

POLICE DEPARTMENT OF THE CITY OF SAN FRANCISCO
San Francisco, March 25, 1943.

To the Editor:—Supplementing telephone conversation between you and members of our Bunco Detail regarding the running of a paragraph in CALIFORNIA AND WESTERN MEDICINE concerning a thief who robbed a patient in the St. John Hospital, following are the facts:

On February 9th last, a patient was brought to the hospital, where he was searched by a male nurse, and the following day he missed $1400. The nurse left and is now a fugitive. We believe that as soon as the money is gone he will seek employment in a hospital. As a protection to institutions, as well as an aid to his apprehension, we would appreciate it if you would run the following in your publication:

"Wanted, by the San Francisco Police Department ROBERT EDWARD WHITE, male nurse, Social Security No. 526-22-9810. Charge Grand Theft. This subject on February 9th robbed a patient in the St. John Hospital and is now a fugitive. Should he seek employment, notify your local Police Department. He is described as 42 years old, 5′5½″, 150 lbs., blue eyes, brown bushy hair, native of Missouri. A noticeable peculiarity is the eyebrows which run across the nose. Your assistance in his apprehension will be appreciated."

We believe that the above paragraph run in your publication, will assist us in individual's apprehension.

Thanking you in anticipation of your coöperation and assuring you of our willingness to reciprocate at any time, I am,

Yours very truly,

CHARLES W. DULLEA,
Chief of Police.

MEDICAL EPONYM

Romberg's Sign

Moritz Heinrich Romberg (1795-1873), professor and director of the Royal Polyclinic Institute of the Friedrich-Wilhelm University, Berlin, described this sign in his *Lehrbuch der Nerven-Krankheiten des Menschen (Textbook of Human Nervous Diseases)*, (Berlin, 1851: Vol. 2, p. 185). A portion of the translation follows:

"If the patient is asked to close his eyes while standing upright, he immediately begins to sway and reel.... I called attention to this pathognomonic sign ten years ago (according to my observation, it does not occur either in other paralyses or in uncomplicated blindness) and have since never failed to find it in any of my numerous patients with this disease."—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Rovsing's Sign

Dr. Thorkild Rovsing (1862-1927), director of the Surgical Clinic at the University in Copenhagen, described "Indirektes Hervorrufen des typischen Schmerzes an McBurney's Punkt [Indirect Elicitation of Typical Pain over McBurney's Point]," in the *Zentralblatt für Chirurgie* (34²:1257-1259, 1907). Being unable satisfactorily to examine in the usual way two patients whom he suspected of having appendicitis, he was able to bring out the typical pain by this maneuver. A portion of the translation follows:

"Both patients showed such unusual sensitiveness to palpation that a careful examination of the region of McBurney's point seemed not only impossible but inadvisable. It occurred to me that the typical pain might possibly be elicited by pressure on the descending colon, in the *left* iliac fossa. I laid my left hand flat on the abdomen and with the right hand forced its fingers down against the colon, compressing it. The hand was then allowed to glide upward toward the sigmoid flexure."—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Pick's Disease

Dr. Friedel Pick (1867-1926), first assistant in the First German Medical Clinic at Prague, presented a discussion, "Über chronische, unter dem Bilde der Lebercirrhose verlaufende Pericarditis (pericarditische Pseudolebercirrhose) nebst Bemerkungen über die Zuckergussleber (Curschmann) [Chronic Pericarditis—Pericarditic Pseudocirrhosis of the Liver—Simulating the Course of Cirrhosis of the Liver, with Observations on the Frosted Liver (Curschmann)]," in the *Zeitschrift für klinische Medicin* (*29*:385-410, 1896). A portion of the translation follows:

"There is a symptom complex (pericarditic pseudocirrhosis of the liver) that simulates one of the mixed forms of cirrhosis of the liver (enlarged liver, marked ascites without jaundice). This results from disturbances in the circulation of the liver caused by a latent pericarditis. These lead to an overgrowth of connective tissue, which produces marked ascites by causing congestion in the portal circulation.

"The condition usually occurs in young persons, but may be seen in later life.

"The following points are to be considered in the differential diagnosis: absence of any etiologic agent for cirrhosis of the liver, a history indicating a previous pericarditis and a previous edema of the legs. Only careful examination of the heart can finally establish the diagnosis."—R. W. B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 4, April, 1918

EXCERPTS FROM EDITORIAL NOTES

Committee on Scientific Program. Very Important.—Your paper, when read, becomes the property of the Medical Society of the State of California, and may be published or refused publication in the JOURNAL, according as the judgment of the Publication Committee dictates. The rules require that your paper as read must be left with the Chairman of the Section before which it is read. . . .

Del Monte.—Every person who is expecting to attend the annual meeting at Del Monte on April 16 [1918], should make immediate reservation if he does not wish to court disappointment. The State Society meeting is placed in the middle of the busy hotel season at Del Monte and rooms will be at a premium. There is every necessity for immediate reservation. Do it now. You can cancel a reservation if absolutely necessary later. You will probably be unable to secure accommodations toward the date of the meeting. . . .

Volunteer Medical Service Corps.—For the purpose of completing the mobilization of the entire medical and surgical resources of the country, the Council of National Defense has authorized and directed the organization of a "Volunteer Medical Service Corps," which is aimed to enlist in the general war-winning program all reputable physicians and surgeons who are not eligible to membership in the Medical Officers' Reserve Corps. It has been recognized always that the medical profession is made up of men whose patriotism is unquestioned, and who are eager to serve their country in every way. Slight physical infirmities, or the fact that one is beyond the age limit, fifty-five years, or the fact that one is needed for essential public or institutional service, while precluding active work in camp or field or hospital in the war zone, should not prevent these patriotic physicians from close relation with governmental needs at this time. . . .

It is intended that this new corps shall be an instrument able directly to meet such civil and military needs as are not already provided for. The General Medical Board holds it as axiomatic that the health of the people at home must be maintained as efficiently as in times of peace. . . .

The Mental Hygiene Movement in California.—Physicians in California should be conversant with the excellent activities of the California Society for Mental Hygiene, a state branch of a national organization which is giving effective and sadly needed service. The mental hygiene movement is well described as a well-organized endeavor to reduce the alarming amount of mental impairment in the United States by making public careful statements of the causes of mental disease, by securing earlier medical treatment, and by preventive social service with individuals threatened with mental breakdown

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, Page 18)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M.D
Secretary-Treasurer

Board Proceedings

At the recent meeting of the Board of Medical Examiners, held in Los Angeles, Dr. Frederick N. Scatena of Sacramento, was elected Secretary-Treasurer, succeeding Dr. Charles B. Pinkham, who retired on February 1, 1943, after thirty years of continuous service to the State of California.

The dates previously set for the San Francisco meeting of the Board of Medical Examiners as July 12 to 15, 1943, were changed to June 28 to July 1, 1943, this at the request of the universities and to facilitate the war effort. Also the date of the oral examination, previously set for August 12th in Los Angeles, was changed to August 9th in Los Angeles.

At the written examination conducted by the Board in Los Angeles, March 9, 10, 11, 1943, some 210 physicians and surgeons and 1 chiropodist presented themselves for examination. This number is considerably larger than the number usually writing the Board examination at the spring meeting and the increase in examinees is attributed to the accelerated courses now being given by our Universities to aid the war effort.

Some 25 licentiates were cited on the Legal Calendar of the Board on charges of unprofessional conduct. The following changes of status were made:

Autard, Eugene Joseph, M.D. Certificate revoked March 9, 1943, under Section 2385 of the Business and Professions Code (adjudicated mentally ill);

Callnon, John W., M.D. Certificate revoked March 9, 1943, under Section 2385 of the Business and Professions Code (adjudicated mentally ill);

Jankelson, Jacob, M.D. Found guilty March 11, 1943; certificate suspended for six months from April 1, 1943, and probation for five years, with specified terms; (Sec. 2392, B. & P. Code);

Robinson, John M., M.D. Certificate restored on March 9, 1943;

Ryberg, Harry, Jr., D.S.C. Found guilty March 9, 1943; placed on probation for three years, with specified terms; (Sec. 2410, B. & P. Code);

Smiley, Henry C., M.D. Found guilty March 11, 1943; placed on three years' probation, without narcotic privileges; (Sec. 2390, B. & P. Code);

Smitherman, Jackson, M.D. Certificate revoked March 9, 1943; (Sec. 2383, B. & P. Code);

Tweedie, Arthur M., M.D. Found guilty March 10 1943; placed on probation for five years, with specified terms; (Sec. 2383, B. & P. Code);

Wood, Leonard D., M.D. Found guilty March 9, 1943; placed on three years' probation without narcotics; (Sec. 2390 B. & P. Code).

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

(Continued in Back Advertising Section, Page 38)



"MANPOWER" . . .
and the Menopause

"MANPOWER" in industry is rapidly changing to "womanpower." And, with so many women on production and assembly lines, the problem of absenteeism and lowered efficiency, particularly among women in their forties, deserves consideration.

It has been estimated that 80 per cent of women in this age group experience menopausal symptoms of varying intensity. Efficiency demands that these workers be physically and emotionally fit. Clinical investigations show that, in a large percentage of cases, they can be kept "on the job" through the use of adequate estrogenic therapy.

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GYNECOLOGY—Two Weeks Intensive Course starting June 28th; Clinical and Diagnostic Courses.

OBSTETRICS—Two Weeks Intensive Course starting April 19.

OPHTHALMOLOGY—Two Weeks Intensive Course starting September 13. Course in Refraction Methods starting May 3.

OTOLARYNGOLOGY—Two Weeks Intensive Course starting September 27.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 22)

together with its closer proximity to the vagina and rectum, has a direct bearing upon the much greater frequency of colon bacillus infections in women; and when we consider that the majority of infections of the upper urinary tract are due to the latter organism, the importance of sex in relation to pathological conditions of the kidney is obvious. Likewise the intimate relationship existing between the venous and lymphatic plexuses of the female sexual and urinary organ is a factor of much significance. . . .

From an Article on "Cardiospasm," by Thos. J. Orbison, M.D., Los Angeles.—This is the name given to a neurosis, the dominant symptom of which is cesophageal spasmodic closure at or near the cardiac end of the stomach during the act of deglutition.

It should be noted that the spasm is not the disease, but a symptom of the underlying nervous imbalance that is responsible for the disturbed nervous tone. . . .

From an Article on "A New Device for Holding Fractures of the Long Bones," by J. A. Simpson, M.D., San Francisco.—The present treatment of fractures of the long bones has not given uniformly good results. While the introduction of the Lane plate has marked a distinct advance in the treatment of these cases, the results have often been disappointing.

The reason for this is not difficult to see; the screws used taper from head to point and cut their own thread in the bone. Living bone, under pressure, may absorb, leaving the screw loose. The plate separates from the

(Continued on Page 28)

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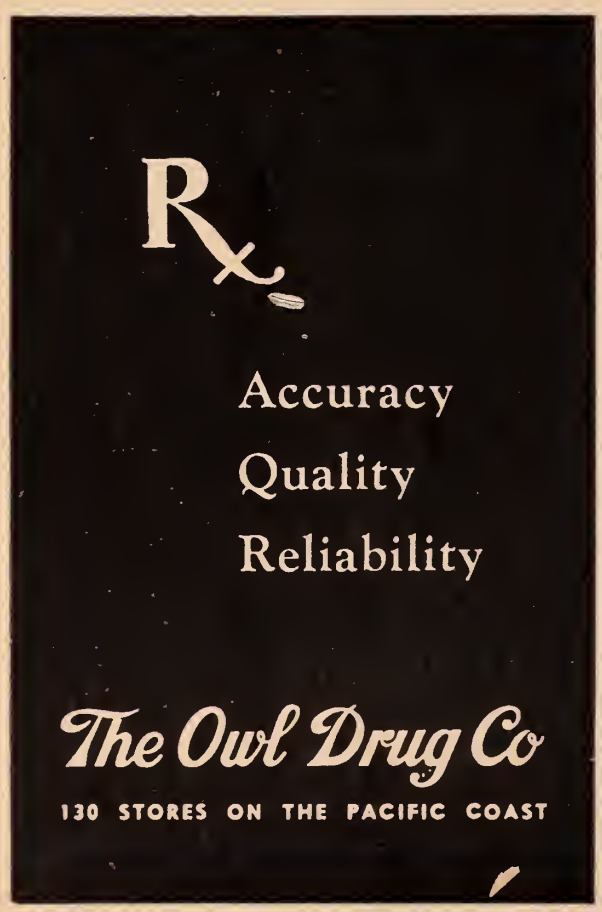


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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

bone and muscle pull brings about shortening and deformity. The loose plate and screws become irritating foreign bodies and have to be removed. The last end of that patient is worse than the first. . . .

From an Article on "Rectal Hemorrhage," by Alfred J. Zobel, M. D., San Francisco.—When blood appears from the mouth or urethra, whether it be in mere traces, free, clotted or mixed with sputum, vomitus or urine, it is generally a matter of much concern to the average individual. He usually consults a physician at the earliest moment, and the probabilities are that every modern scientific method will be employed to discover the source of the bleeding. . . .

From an Article on "The Management of Surgical Risk. A Review of 100 Kidney and Prostate Operations, and 50 Cases of Enlarged Prostate Not Operated Upon," by Frank Hinman, A.B., M.D., San Francisco.—Preoperative, operative and postoperative periods of management of certain surgical cases are often so interdependent that careless attention to the details of any one may counteract an absolutely perfect execution of the others. Mismanagement brings disaster most frequently in cases with marked clinical abnormalities. The commonest abnormality in old men with enlarged prostates is renal disturbance, and the problem is similar to that which occasionally arises in renal surgery. . . .

From an Article on "Acute Gastro-Duodenal Perforations. Treatments, Diagnosis, Report of Six Cases. Four

(Continued on Page 30)

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

Recoveries," by Edmund Butler, M.D., San Francisco.—About 15 per cent of gastric ulcers and about 25 per cent of duodenal ulcers rupture, according to Allaben, in the Illinois Medical Journal, 1909. Musser maintains that 28.1 per cent of all ulcers perforate. Ulcers are more frequent in the male, and perforations occur in much greater proportion than in the female. Acute ruptured ulcers are most often located on the anterior wall of the stomach and first portion of the duodenum. The histories of cases of acute rupture are all somewhat similar. Previous gastro-intestinal disturbance may or may not be a part of the history. It is difficult and often impossible to get a satisfactory history from patients suffering from a ruptured ulcer.

The history in the chronic perforations may be misleading, but it is not in these cases that an error in diagnosis is so disastrous; so in this paper, only acute perforations will be considered. . . .

EXCERPTS FROM CORRESPONDENCE: WORLD WAR I

From Surgeon U. R. Webb, U.S.N.
U. S. S. Solace.

To the Editor:

Your letter of February 14, 1918, has just reached me. I was detached from duty at Mare Island and ordered to command the "Solace" a few days after writing you concerning the draft for physicians, etc. Dr. Woodward has taken up that work, I believe. We still need physicians. The work increases with the expansion of the Navy. I wish I could write you of our activities, but the censor forbids.

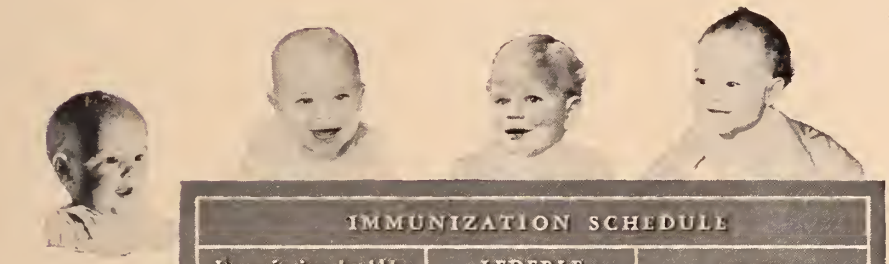
(Continued on Page 32)

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EVERY PRACTITIONER should be on the alert to encourage immunization programs and to urge immunization in his private practice. The migration of families by the thousands, almost universal decrease in home supervision of children, increasing personal contacts throughout industry, and the relative scarcity of physicians combine to increase the likelihood of the spread of infectious diseases.

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EMILE HOLMAN, M. D.
(Stanford Hospital), Consultant, Thoracic Surgery

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

Health conditions are good. Everyone works with enthusiasm, the morale is high, defeat is unthinkable

With best wishes, sincerely,

U. R. Webb

Somewhere in France, Near Where the Cannons Can Be Heard

January 29, 1918.

We are at present out in the woods getting back our health from the trip we had coming to this place. I wish now I had studied my French a little more before starting across. However, I am gradually learning the lingo. My teacher has just left on his gallant steed announcing that target practice is over for the day. They are all fond of American cigarettes and tobacco, these French soldiers that we come into contact with, quite often paying fabulous prices. . . .

(Signed) G. B. Wilcox,
162nd Infantry, Medical Dept.

San Francisco Polyclinic War Letters. Notes From Camp Lewis

December 13, 1917.

Since coming to Camp Lewis my experiences have been wide. You know when a civilian enters the military the first thing they want to know is how to act. The acting will work if they know how to salute. This is particularly so if they have a uniform on. At first it was hard to pick a newcomer but now it is very easy For instance a captain rushes up to you beaming all over. and saluting, wants to know where headquarters are and who is in charge. Immediately he is told to go to the Y. M. C. A. Building, where Major Latrine holds forth, incidentally asking if he has an old umbrella. He will go and do as he has been told. Then about fifty men gather around for the fun. So much for the funny side of military life. . . .

(Lt.) Raymond A. Babcock,
Ambulance Co. No. 364, 316 Sanitary Train, Camp Lewis, Wash.

From Dr. Sterling Bunnell, Secaucus, New Jersey.—Since the first of the year I have been stationed at Hoboken, New Jersey, the port of embarkation, awaiting the arrival of our San Francisco unit. Have been at first given the job of learning army hospital management. It is most exact, but a very smoothly running system when working perfectly. I am now established in the Army Hospital, Secaucus, N. J., not doing surgery, but taking care of my share of the 350 contagious cases, and acting as supply and property officer for the hospital. Lieut. Harold Fletcher of San Francisco is one of us, and there are but four of us doing the medical work of the hospital. . . .

From Dr. Walter S. Johnson, Base Hospital, Camp Kearny.—The Surgeon General's office at Washington assigned me to duty at the Base Hospital, Camp Kearny, in connection with venereal diseases, and I am in charge of this department. It is a very large service, and the venereal incidence at one time was a gigantic problem. The great bulk of the work came before our base hospital was completed and a temporary hospital was under canvas. Supplies for carrying out our work had not arrived and the task of having to care for so many taxed the ingenuity of most of the medical and surgical staff. . . .

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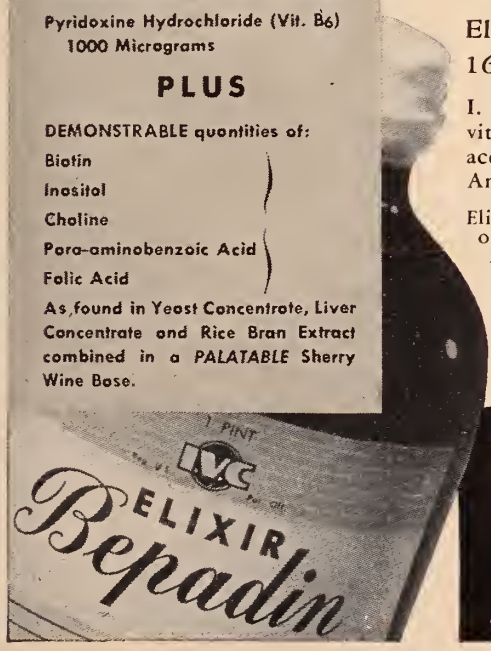
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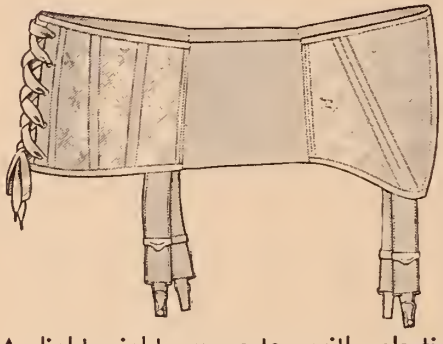
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TWENTY-FIVE YEARS AGO

(Continued from Page 32)

From Dr. Bruce Foulkes, Camp Funston, Kansas

I arrived M.O.T.C., Fort Riley, Kansas, on June 1st. There was no one at the station to meet us as guide, so we wandered around the post trying to orientate ourselves. We found that we were in a reservation of 22,000 acres. The distance of a mile between buildings was the rule rather than the exception. After lugging our suitcases and overcoats for about two hours, incidentally on account of the heat, our white collars were warped and our personal appearance generally mussed up, we located the Adjutant's office, at which we registered. . . .

Excerpts from a Report of the Los Angeles County Medical Association Meeting, held on February 7, 1918.—The following resolution was adopted:

Resolution—In re Contract Practice in Industrial Compensation Work.

(Note—The following resolution was presented by the Special Committee sending out the questionnaire postcard, and has been adopted by the Board of Councilors, subject to ratification by the Society at one of its meetings.)

WHEREAS, At the Santa Barbara meeting of the Medical Society of the State of California, at which was adopted the minimum fee table for industrial accident work, it was agreed that this work should be carried on between every public or private insurance company, and an attending surgeon, upon the basis of an individual bill, rendered as per the above referred to minimum fee table; and that no contract agreements, either direct or indirect, whereby this agreement would be violated, in

(Continued on Page 36)

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Page 34)

that a lesser fee would be accepted, would be allowed by either the State Medical Society or any of the public (state) or private insurance companies; and

WHEREAS, The recent referendum vote of the Los Angeles County Medical Association, as published in the November 15, 1917, Bulletin of the Society, clearly showed, by a very large majority, that the members were in full accord with the Santa Barbara State Society agreement; now therefore be it

Resolved, By the Board of Councilors of the Los Angeles County Medical Association (the Association in general meeting ratifying the same on ————), that any violation of the Santa Barbara State Society agreement, as outlined above, shall automatically subject the member who does so to such disciplinary measures as in the judgment of the Ethics Committee and Board of Councilors seem proper (as per the disciplinary code printed in the State Journal of January, 1918, page 53). . . .

A humorist is one who listens impatiently to your story just to get the opportunity to tell a "good one" of his own.

"Class is dismissed," snapped the exasperated Anatomy professor, after the weekly oral examination, "and don't flap your ears as you go out!"

"Does yo' take dis woman fo' yo' lawfully wedded wife?" asked the colored parson, glancing at the diminutive, watery-eyed, bow-legged bridegroom, who stood beside the 250 pounds of feminine assurance.

"Ah takes nothin'," gloomily responded the bridegroom. "Ah's bein' tooked!"



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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 260)

News Items

"Governor Earl Warren today appointed Dr. J. R. Walker, Fresno eye, nose and throat specialist, a member of the State Board of Medical Examiners for a four-year term. Dr. Walker, associated with his brothers, Drs. G. W. and B. F. Walker, has practiced in Fresno since 1902. He is former president of the Fresno County Medical Society and served as a vice-president of the California Medical Association. The Fresnan holds a certificate from the American College of Surgeons and is a member of the American Board of Ophthalmology. . . . He succeeds Dr. W. A. Swim of Los Angeles, whose term expired. . . ." (Fresno *Bee*, February 4, 1943.)

"Members of the medical profession serving full time on active service in the Naval Reserve or the reserve forces of the Army, are not subject to the payment of the Business and Professions Code annual tax or registration fee, according to an opinion by Robert W. Kenny, Attorney-General. Kenny pointed out that the Naval Reserve is a component part of the United States Navy and is under the jurisdiction of the Secretary of the Navy, and likewise held that the reserve forces of the Army are a component part of the Army. 'The activities of those members of the reserve corps,' said Mr. Kenny in his opinion to the Board of Medical Examiners, 'who are on active duty, are not different from the activities of those of the regular Army or Naval service.' He therefore held that such reserve groups were specifically

(Continued on Page 40)



• *Violence during grand movements is pictured by Paul Richer, one of the distinguished artists of medicine, in his Etudes Cliniques sur L'Hysterio-Epilepsie (1881).*

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1. Lennox, W. G.: Jl. A.M.A., Oct. 10, 1942

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

exempted under the Business and Professions Code. Included in the same exemption, according to Kenny, were those serving in the Public Health Service." (San Francisco *Recorder*, February 23, 1943.)

"Charging that some California physicians are engaged in unAmerican activities, Senator Tenney announced he will introduce a senate bill calling for revocation of licenses of members of the medical profession who are members of subversive organizations. Said Tenney: 'During the time that the legislative committee on unAmericanism was making its investigations, we obtained conclusive evidence that certain doctors in various sections of the State were actively engaged in subversive movements. The legislation which I intend to introduce soon is aimed at them.'" (Sacramento *Bee*, January 27, 1943.)

"A San Francisco Superior Court writ of mandate nullifying the State Board of Medical Examiners' revocation of Dr. George Carl McPheeters' license as a physician and surgeon has been entered in the medical register in the Fresno County Clerk's office. . . . The State Board was commanded to cancel and annul the revocation and the Fresno County Clerk was ordered to enter notice of the nullification with Dr. McPheeters' medical certificate registry. Dr. McPheeters' license to practice was revoked by the State Board October 21st, following an all-day hearing in Sacramento in which he was found guilty of offering to procure an abortion on a San Francisco

(Continued on Page 42)



Some men are so clever!

Take my boss for instance . . .

Yesterday, I overheard him talking to another doctor about infant feeding.

"Jim," he said, "I'll tell you why you never have any time to spare. You get yourself tied up with a lot of unnecessary work.

"You believe in prescribing plain cow's milk modified. Haven't you found out that S-M-A* will save you a lot of unnecessary questions? Cut out a lot of bothersome arithmetic?



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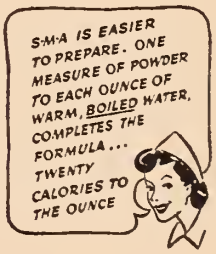
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Well, you can see why I think my boss is so clever. Why don't you try S-M-A in your own practice, doctor? See if you don't like it better.

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The course comprises examination of patients; tests, models, and photographs; diagnosis and selection of method of correction; the properties of various orders of skin grafts and variance in their application; bone, cartilage and nerve grafts; readjustments and replacements; fresh wound treatment; pre-operative care; anesthesia; operative procedures; wound closing and minimum scar; follow-up and infection problems; keloids. The course covers the field of correction of disfigurements and replacement of traumatic loss and congenital deficiency. Exposition of cases, lectures and cadaver demonstrations.

For Information Address: **MEDICAL EXECUTIVE OFFICER, 345 West 50th Street, New York City**

BOARD OF MEDICAL EXAMINERS

(Continued from Page 40)

woman. Joseph Williams, special agent for the board, testified Dr. McPheeters admitted performing the illegal operation but contended it was made necessary by an infection." (Fresno *Bee,* February 6, 1943.)

"Complaint of a 28-year-old woman, the mother of three children, yesterday resulted in the arrest of Dr. William E. Glaeser, 52, 196 Guerrero Street and his office nurse, Mrs. Lillian Arto, 38, 801 Fillmore Street. In San Francisco Hospital, and critically ill, is Mrs. Antonio Lucero, 226 Clinton Park, who informed police that Friday afternoon she submitted to an illegal operation at Dr. Glaeser's office. Mrs. Lucero was removed to the hospital from her home Sunday, suffering from an acute infection, and physicians declare her condition is grave." (San Francisco *Chronicle,* March 9, 1943.)

"Dr. Karl John Weberg, 68-year-old chiropractor, was found guilty yesterday in Superior Court of having performed an illegal operation. The jury of nine men and three women went out at 5 p.m. and returned with the verdict approximately 15 minutes later. Judge Frank C. Collier declared that he would pronounce sentence next Tuesday and ordered Weberg into the custody of the sheriff until then. Defense Attorney Archie D. Orme stated that he would enter a request for probation at that time. The case was prosecuted by Charles Hollopeter, deputy district attorney. Weberg is president of the Pasadena School of Chiropractic, at 897 North Fair Oaks Avenue." (Pasadena *Post,* February 19, 1943.)

"One bit of medical lore that was missing from the vocabulary of Harry Browner, 43, was that it is against federal law to impersonate a doctor in the U. S. Public Health Service, the Federal Grand Jury contended today in an indictment of Browner. The indictment charged that Browner, a clerk, made such an impression on Mrs. Maude Walbie with his alleged rôle of a physician that she loaned him $20 to tide him over until his 'government check' arrived." (Los Angeles *Herald and Express,* March 5, 1943.)

Doctors All Right Socially, But Nil When McLemore's in Star Role.—Still somewhere in bed (Henry McLemore writing). I finally called in a doctor today. As I explained in yesterday's Pulitzer prize article. I have been treating a bad cold myself, pretending that it was a patriotic gesture on my part, much having been written on the shortage of doctors for civilians.

To tell the truth, the only reason I haven't called one in long before this is that I am mortally afraid of doctors.

* * *

I like doctors socially. They make good golf companions. I like to play bridge with them, and like to have dinner at their homes, as most of them set good tables. But, let a doctor enter a sickroom, where I am the central decoration, and he scares the wits out of me—and I'm the sort of man who needs to have a few wits scared into him, not out of him.

Right off, I start lying to doctors. I always tell them I feel fine, that I haven't an ache or pain of any kind. I have told doctors this when I could scarcely hold up

(Continued on Page 44)

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I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

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I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

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* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton St., Fresno.



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350 Madison Avenue, New York, N. Y.

(Continued from Page 42)

my head, for fear an honest answer would furnish them with a clue as to what was wrong with me. If there is one thing that I don't want to know when I am sick, it is what is wrong with me. When I am well and strong, and going about my work, I wouldn't mind having a doctor tell me there was something dreadfully wrong with me. But to be told that I had some specific ailment when I was sick in bed and couldn't fight it off, would be more than I could stand.

* * *

The only reason I called a doctor today was because of things that began happening around my home

In the first place, the dog started practicing baying outside my window.

In the second, the maid sent my dark blue serge to be pressed. It's a suit I haven't worn in months.

The doctor came. He was a new one, and he thumped and pounded and oh-ed and ah-ed me, and asked me questions to which I gave false answers. I thought back over the doctors of my experience.

* * *

The doctor I had today was young and cheery. I don't know when I have ever disliked a man so much. It's probably a part of modern medicine, but he wanted to know everything about me from the time I could remember. He seemed to regard my cold as the result of something I had done in early childhood. Before he got through, I didn't know whether he was a doctor or a man who was thinking of doing a biography of me. I got only one satisfaction out of his whole visit—that is, that he never got one word of truth out of me. He left believing that I was born of millionaire parents in a villa in Cap Antibes, and that I felt no symptoms of a cold, whatsoever.—Sacramento *Union*, September 16.



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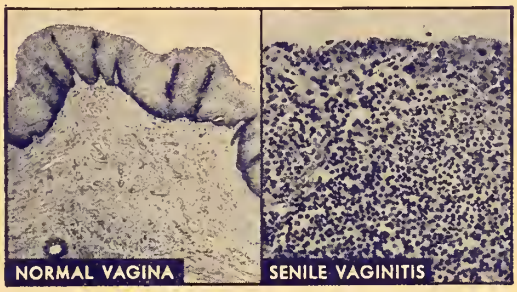
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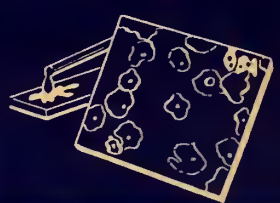
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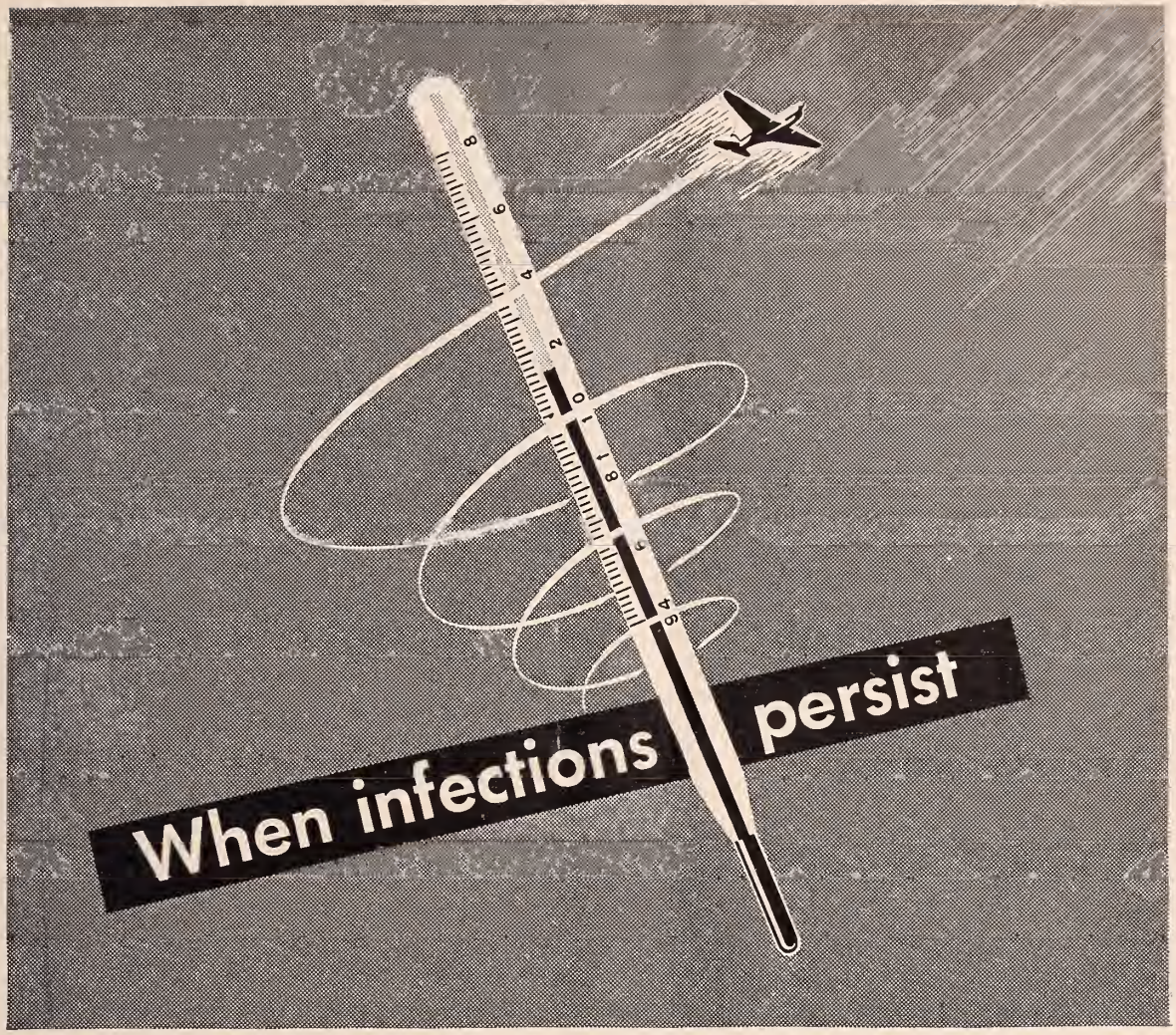
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2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.*
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2212 W. 3rd Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.*
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, C. Glenn Curtis, 323 N. Pomona Street, Brea.
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, W. J. Van Den Berg, 1127 11th Street, Sacramento.
Secretary, Henry L. Saverien, 2626 L Street, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. Don Rolph, 640 National Ave., National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, 1009 Morro, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

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Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

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President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
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Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
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Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

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Meeting, *Second Monday.*

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Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
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President, Frank L. Doane, Red Bluff.
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Tulare County Medical Society
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Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting *Second Tuesday, Ventura County Country Club.*

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Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
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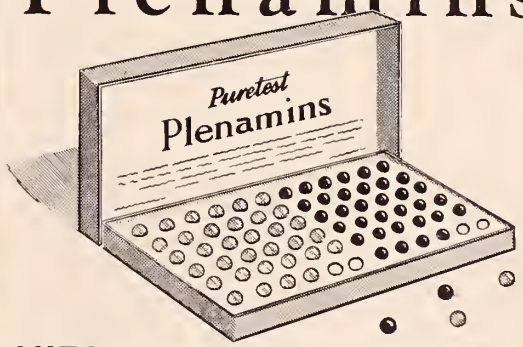
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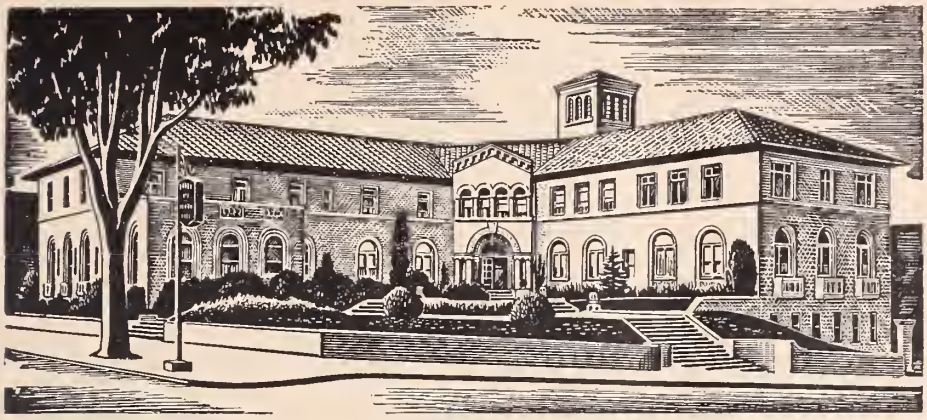
President, Ray B. McCarty, 3116 Main Street, Riverside
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Dictionary of Bio-Chemistry and Related Subjects. Editor-in-Chief William Marias Malisoff, Professor of Bio-Chemistry at the Polytechnic Institute of Brooklyn. Cloth. Price $7.50. New York: The Philosophical Library, 1943.

A Text-Book of Pathology. An Introduction to Medicine. By William Boyd, M.D., LL.D., M.R.C.P., Ed., F.R.C.P., Lond., Dipl., Psych., F.R.S.C., Professor of Pathology and Bacteriology in the University of Toronto, Toronto; Formerly Professor of Pathology in the University of Manitoba, Winnipeg, Canada. Fourth edition, thoroughly revised. Cloth. Price $10.00. Pp. 1008, illustrated with 490 engravings and 29 colored plates. Philadelphia: Lea and Febiger, 1943.

Primer of Allergy. A Guidebook for Those Who Must Find Their Way Through the Mazes of This Strange and Tantalizing State. By Warren T. Vaughan, M.S., M.D., Richmond, Virginia. Second edition. Cloth. Pp. 176, with illustrations by John P. Tillery. St. Louis: The C. V. Mosby Company, 1943.

Flying Men and Medicine. The Effects of Flying Upon the Human Body. By E. Osmun Barr, M.D., with an introduction by James H. Defandorf, Colonel, United States Chemical Warfare Service, and a Foreword by Bernard L. Jarman, M.D., Lieut. Colonel, Medical Corps, U.S.R. Cloth. Price $2.50. Pp. 270, illustrated with drawings and diagrams. New York and London: Funk and Wagnalls Company, 1943.

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BOOKS RECEIVED

(Continued from Page 7)

Synopsis of Diseases of the Skin. By Richard L. Sutton, M.D., Emeritus Professor of Dermatology, University of Kansas Medical School; and Richard L. Sutton, Jr., M.D., Assistant Professor of Dermatology, University of Kansas Medical School. Cloth. Pp. 481, with 413 illustrations. St. Louis: The C. V. Mosby Company, 1942.

The Kenny Concept of Infantile Paralysis and Its Treatment. By John F. Pohl, M.D., Clinical Assistant Professor of Orthopedic Surgery, University of Minnesota; Attending Orthopedic Surgeon, Minneapolis General Hospital, in collaboration with Sister Elizabeth Kenny, Honorary Director the Elizabeth Kenny Clinics of Australia; Honorary Director the Elizabeth Kenny Institute, Minneapolis; Guest Instructor University of Minnesota Medical School, with a Foreword by Frank R. Ober, M.D., President, The American Orthopedic Association. Cloth. Price $5.00. Pp. 368, with 114 explanatory photographs. Saint Paul, Minneapolis: Bruce Publishing Company, 1943.

Sandoz Chemist Honored.—The faculty of the University of Berne has conferred the degree of doctor of pharmacy, honoris causa, on Dr. Arthur Stoll, Sandoz Chemical Works, Inc., of Basle, Switzerland, in recognition of his contributions to the chemistry of medicinal plants. Dr. Stoll was first to describe new methods to isolate active principals of drugs heretofore available only in the form of unstable galenicals. The isolation in pure form of such principles has not only widened their therapeutic application but has opened entirely new indications owing to specific actions not obtainable with the crude drug (i.e., ergotamine). This is the first time the faculty of medicine of the University of Berne has conferred this honorary degree.—*Science*, April 16, 1943.

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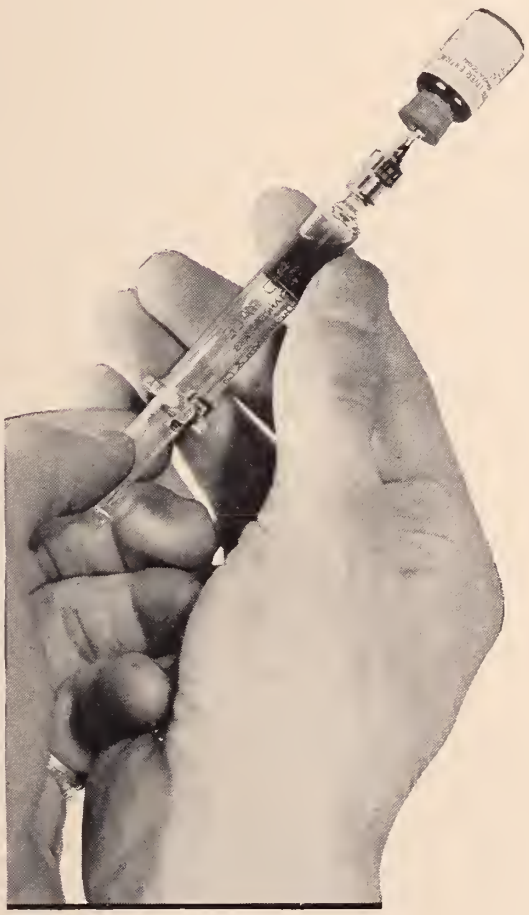
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RADIOLOGIST—Eligible for the American Board and draft exempt, with modern shockproof x-ray equipment, wishes association with individual or group in the vicinity of San Francisco or Los Angeles. Would like straight radiology or radiology and medicine. Remuneration must be above the average, or would invest and aid in the formation of an ethical group with a future Box 7090, California and Western Medicine.

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TWENTY-FIVE YEARS AGO

(Continued from Back Advertising Section, Page 312)

Certain lessons and guides for the future are drawn from the results of the first draft which are worthy of consideration. It directs attention to the strategic necessity of the three vital industrial fields of shipbuilding and manning, munitions manufacture, and agriculture. The order of mention of these three is significant of their relative importance for the war. Emphasis is placed on the reasons leading to a complete revision of the draft regulations and the classification of all men in the draft age according to certain rules. The first draft showed itself a powerful force in controlling and distributing labor throughout the country. Later it may be necessary for the Government to draft labor directly, a proceeding well within its powers and rights. But before such a necessity, it would seem that the principles of the revised draft should be tested thoroughly as they give promise of functioning to this desired end. . . .

The Declining Civilized Birth Rate.—It is an undisputed fact that the birth rate falls as civilization advances. Birth control and civilization go hand in hand. It is also an undisputed fact that the portion of the population of the United States which is economically and socially (*not* fashionably) lower, is most productive or better, reproductive. In the last three and a half decades the trend of European immigration has swung from the north to the south. Whereas previous to this period, four-fifths of the immigrants were Scandinavians, north Russians, north Germans, and from the English isles, during this period

(Continued from Page 16)

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

TWENTY-FIVE YEARS AGO

(Continued from Page 14)

and up to the great war, four-fifths of the immigrants were from south and east Europe, and comprised Slavs, Balkan races, south Italians and Greeks. The result has been a significant change in the rate of Americanization of the new elements, and a tendency to segregation of racial types and perpetuation of racial customs and ideals. This is not desirable from the American standpoint. . . .

Physicians' Rebates from Dealers.—It is an established principle of medical ethics that no physician should accept a fee from another physician for referring patients. A corollary of this makes it unethical for a physician to pay fees to *anyone* for referring patients. If it is true that some physicians persist in this reprehensible practice of fee splitting then they should receive summary action from their local societies and short shrift in the good graces of their more honest and respectable fellows. On these matters there is common agreement, at least in the medical profession. In the matter of rebates from drug houses for patients' prescriptions, and from surgical manufacturing houses for apparatus and appliances ordered for patients, there seems at first glance to be a decided difference. And yet, as we pointed out last month [in the April, 1918 issue], (Physicians' Commissions and the A.M.A., Editorial), exactly the same principle is involved. The patient has a legitimate right to know to whom and for what he is paying his money. The physician has no professional or ethical right without the knowledge of the patient, to collect two fees for the same service rendered. . . .

(Continued on Page 18)



The art of anatomic illustration entered a new epoch upon the publication of the Tabulae Anatomicae of Giulio Casserio (Venice, 1627). This female figure is one of Casserio's most beautiful copperplates.



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For patients requiring high potencies, and for those who do not tolerate oil injections.

THEELIN AQUEOUS SUSPENSION provides the same pure, natural crystalline estrogen as Theelin in Oil, and the same effective clinical results may be expected in the treatment of menopausal syndrome and other conditions due to diminishing estrogenic secretion. Theelin Aqueous Suspension is administered intramuscularly. Normal saline solution—no suspending agent—is used in preparing this product and the ampoule need only be shaken gently before the preparation is drawn into the syringe.

The uniform potency of Theelin is certified by the Laboratories of both Parke, Davis & Company and St. Louis University. Kapseals Theelol (Oral) and Theelin Suppositories (Vaginal) are available for maintenance therapy and for use in milder hypogonadal conditions.

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1-cc. ampoules, each cc. containing 2 mg. (20,000 I. U.) of Theelin suspended in normal saline solution.

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MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

(Continued from Page 16)

Nurses for the Navy.—The Navy Department has issued a call for an unlimited number of hospital corpsmen for duty on board ships as soon as they finish the required course of instruction at the Naval Hospital Schools. . . .

Experience as a nurse or knowledge of pharmacy is required for applicants who desire to enlist in the rating of hospital apprentice, first class. . . .

Manuscripts from Medical Officers in Army.—The large number of medical officers recently joining the medical department direct from civil life, and unfamiliar with the Army regulations governing the publication of scientific papers, has resulted in a number of papers being published in various journals without authority from the Surgeon General's office. At the request of the Surgeon General of the Army, all manuscripts hereafter received [after May, 1918] and accepted for publication, from doctors in the service, unless already properly and officially approved, will be forwarded direct to the Surgeon General's office in order to obtain such authority. To avoid this, medical officers desiring publication of professional papers will submit two copies to the Surgeon General with request for permission to publish same. Upon approval, a copy will be forwarded to the journal designated by the officer for publication.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Regulation of the Practice of Medicine in California Since 1914," by Harry E. Alderson, M. D., San Francisco. (Associate Clinical Professor of Medicine, Stanford University Medical School; Member California State Board of Medical Examiners.)—The present Medical Practice Act first became effective in August, 1913. It was amended in 1915 and in 1917. A movement is under way to have it further amended. Each amendment is apt to mean a weakening of the law. The object in presenting this paper is to stimulate interest in the direction of preventing further unfavorable changes by the legislature to meet early in 1919. The California State Medical Society is large enough and powerful enough to prevent the passing of freak medical legislation if it will only use its influence. . . .

From an Article on "Amebiasis: Its Radical Cure with Combined Emetin and Salvarsan Products," by Herbert Gunn, M. D., San Francisco.—For some time after the introduction of emetin hydrochloride in the treatment of amebic dysentery it was believed by many that an amebicide had been found which, if properly employed, might be expected to destroy the amebae, relieve the symptoms, and result in most cases in a cure. While it is still held by some observers that it is an amebicide, it is conceded by most that it has no effect in destroying the encysted forms and that recurrences are the rule after clearing up symptoms by its use. Further, it was shown by Allen, Baermann and others that emetin does not destroy the amebae in the intestinal tract to the extent that the amelioration of symptoms would lead one to believe. Attention has been called repeatedly to the ill effects

(Continued on Page 20)

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

sometimes following the use of emetin, such as muscular weakness, especially marked in the lower extremities, and often persisting for weeks after the drug has been discontinued. . . .

From an Article on "Acute Gastro-Duodenal Perforations," by Edmund Butler, M. D., San Francisco. (Continued from April Journal, 1918.)—The early cases do not always require drainage. It is safer to use a soft rubber tube reaching into the right kidney pouch or the left subphrenic space.

As a rule, subphrenic abscesses are the complication of chronic perforating ulcers or of cases of acute perforation which have been followed by a diffuse suppurative peritonitis. In cases of well advanced peritonitis, suprapubic drainage is indicated. In closing the abdominal wall, plain catgut in the peritoneum and figure-of-eight sutures of silk worm catgut, including the fascia, fat and skin are most often used. . . .

From an Article on "The Control of Epidemic Meningitis, with Some Observations Made During an Epidemic at the United States Naval Training Station, San Diego, California," by Frank L. Kelly, M.D., Gr. P.H. Epidemiologist, California State Board of Health, Berkeley, California.—Before taking up the methods for the control of meningitis, it will be advisable to consider the various types of the disease. The division into sporadic and epidemic meningitis may be arbitrary and does not

(Continued on Page 22)

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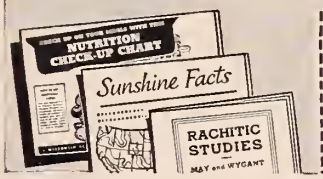
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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

mean that the two are different clinically, for the epidemics of the disease very probably arise from the sporadic cases. For this reason the terms endemic and epidemic may more correctly express the difference. However, the distinction is of practical value in designating the forms of the disease to which different methods of control are adaptable. . . .

From an Article on "Arch Defects of the Human Foot," by Ethan H. Smith, M.D., San Francisco.—In the past the profession of medicine has given all too little attention to defects of the arch of the human foot. They have either not paid heed to it at all, or have heedlessly sent the patient to a shoe store or instrument house, with advice to secure a "good arch support." They have never taken the trouble to find out whether or not such a thing as a good arch support was on the market, taking it for granted that because they were on sale they must necessarily accomplish the purpose for which they were made. . . .

From an Article on "Gonorrhea in Women," by William E. Stevens, M.D., San Francisco.—Gonorrhea in women, although a most serious and frequently fatal disease, the immediate and remote consequences of which are probably responsible for more suffering and unhappiness than all other diseases combined, is nevertheless more often neglected than any other pathological condition of the female genito-urinary tract. At the present time when so much depends upon the health of our armed forces the necessity for its detection and eradication is of first importance, for notwithstanding the measures directed toward the suppression of prostitution and illicit intercourse, prophylactic treatment and punishment for concealment, the number of infections among our soldiers at home and abroad is sufficient to cause the army officials grave concern as it ranks first in the list of infectious diseases as a cause of physical debility. In a recent communication the Surgeon General of the public health service states that venereal disease is the most serious problem from the standpoint of military efficiency which confronts the army authorities today. . . .

Excerpts from State Society: The Del Monte Meeting.—About three hundred members were present at the annual meeting of the Medical Society of the State of California at Del Monte [held April 16-18, 1918]. The following officers were elected:

President, Dr. C. Van Zwalenburg, of Riverside; first vice-president, John H. Graves, of San Francisco; second vice-president, Dr. Ferdinand Stabel, of Redding; secretary, Dr. Saxton Pope. . . .

Excerpts from Military News: Important Parcel Post Notice.—The attention of the public is called to the fact that every pound and every ton of parcel post which is sent from the United States, but which can be bought by the soldiers in France, forces off the ships, ammunition and other needed war materials. The immense volume of parcel post sent to France containing articles which can be purchased cheaply by the soldiers in France, and which are not usually shipped from the United States but are obtained in Europe, principally from Spain, Switzerland, and Italy, is shown by the fact that an investigation of 6,000 sacks of parcel post disclosed 3,874

(Continued in Back Advertising Section, Page 26)

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EDITOR GEORGE H. KRESS

Committee on Publications

George W. Walker (Chairman) Fresno 1943
F. Burton Jones Vallejo 1944
Francis E. Toomey San Diego 1945
Secretary and Editor ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

72ND ANNUAL SESSION: AT LOS ANGELES, MAY 2-3, 1943

The current issue of the OFFICIAL JOURNAL is in press at the time this year's annual session is being held in the Hotel Biltmore, Los Angeles, on Sunday, May 2nd and Monday, May 3rd. The April issue contained the complete program. All indications point to general and section meetings that will be of interest and value.

The Committee on Scientific Work is indebted to military authorities who are associated with the medical departments of the Army and Navy, and to colleagues in the active service with the Armed Forces, for generous coöperation; not only in connection with papers that will be given on topics related to military medicine but also in making possible the presentation of exhibits and films dealing with military subjects.

Conforming to custom the June issue will present complete reports of the proceedings of the House of Delegates, the Council, and will also give information on other matters of special interest. During the coming year, many of the papers will receive place in the text pages of CALIFORNIA AND WESTERN MEDICINE, so giving members who were not able to attend an opportunity to partake, if only by indirection, somewhat of the spirit of this session in which military and related medicine will be emphasized.

PRE-CONVENTION BULLETIN

Reports by the County Society Secretaries.—The April issue of CALIFORNIA AND WESTERN MEDICINE contained the "Pre-Convention Bulletin" in which appeared two major groups of reports: (1) Reports of Officers and Committees (pp. 181-203), and (2) Reports of the Component County Medical Societies (pp. 204-212).

Attention of members is directed to these important summaries, the hope being expressed, if time has not been available for their perusal, that the issue may be laid aside for future consideration. A hasty glance at the topics presented by the many workers of the Association whose names are signed to the communications, is reassuring evidence that the medical profession continues to have many disciples who gladly give of their best in promotion of activities that are designed to conserve the interests of the public health and medical standards.

The reports submitted by the secretaries of the forty component county societies,—which

make up the federacy, league or alliance known as the California Medical Association—are of special interest under present conditions, and furnish profitable reading for all county society officers. Since, what one county society is able to do, should be worthy of careful consideration by other county units.

The strength of organized medicine comes back in good part to the county medical societies, since these are the basic units through which membership in state and national organizations is determined. Also, these county groups, with jurisdiction in their respective geographical areas and communities, set the patterns and standards whereby the medical profession is judged by lay citizens. True, the estimate of the lay public is also based in large part on the professional and civic services rendered by individual physicians. It is important to recognize, however, no matter how excellent may be the reputations of individual practitioners in any community or county, that as regards the organized profession of medicine, a community spirit among physicians themselves must be existent, if the standards of scientific medicine are to be properly appreciated, and the good will of the community, secured.

* * *

Organized Medicine Conserves Scientific Medicine.—It must not be forgotten that during the last decade or so, a persistent campaign has been carried on in many quarters to break down the esteem in which the medical profession was formerly held by the great majority of citizens. The protection against such undeserved onslaughts necessarily falls upon the component county societies. The State and National Associations can coöperate in measures designed to protect the best interests of the public health and of the standards of scientific medicine, but the real support resides within the membership of the component county units. That is why the county society reports presented in the April issue are worthy of special perusal.

It is heartening to read of the many activities of the county societies, and to note the spirit of loyal and generous endeavor which animates the physicians throughout the length and breadth of California. Therein lies the hope of the profession in the battles still ahead.

ON PROCUREMENT OF MEDICAL OFFICERS FOR THE ARMED SERVICES

Report on an Address by Captain Philip K. Gilman.—On Tuesday, April 20th, Captain Philip K. Gilman gave an address before the Commonwealth Club of San Francisco. In its report thereon, in the issue of April 23rd, the *San Francisco Examiner* made two erroneous statements, which it acknowledged when called to its attention:

A portion of the letter sent to the *Examiner* follows:

"Your attention is called to the report concerning the address given by Capt. Philip K. Gilman, U.S.N.R., who is the medical officer in charge of the northern division of the United States naval office of naval officer procurement. (Doctor Gilman is not a former president of the California Medical Association, but for some years has been the chairman of its council.)

"The item stated: 'Nine hundred doctors must be recruited immediately from northern California, and three hundred from the southern part of the State.' This is the reverse of what Captain Gilman stated, and the error should be corrected.

"It is unfortunate that your reporter also deemed it necessary to inject the statement that Doctor Gilman 'gave no explanation of why hundreds of Army and Navy doctors are sitting around doing little or nothing, while hundreds of others are being used, not for medical work, but for paper work.'

"There was nothing in Captain Gilman's remarks to warrant the above statement, which is most detrimental to the efforts of the surgeon generals of the Army and Navy to build up their respective medical corps so that the best medical and surgical service may always be available to soldiers and sailors in our armed forces.

"It should be remembered that, just as it is necessary to maintain in continental America a pool of millions of men who are being trained so that they may be available for military work, so also is it equally important that an adequate pool of medical officers and personnel be likewise available, in case occasion should demand, that they could be called upon for instanst service, either on the American continent, or in foreign lands."

A paragraph in the letter that was not printed by the *Examiner*, stated:

"I feel sure you will agree that it is vital to our Country's best interests that misconceptions in matters such as the above should not be spread. May we hope that *The Examiner* will take occasion to promptly rectify the erroneous impressions given in the article referred to?"

* * *

Reply by the Editor of the "San Francisco Examiner."—It is interesting to note the comments contained in the reply of the *Examiner* editor (printed in black face type):

"(Editor's Note: The errors regarding Doctor Gilman's title and the transposition of figures on recruiting in northern and southern California are herewith acknowledged. The statement that both Army and Navy are hoarding, misplacing and misusing hundreds of doctors is hereby reiterated. The whine about needing to train doctors is an evasion of the facts. Doctors who are doing little or no work in the Army and Navy, doctors who are doing work that could be done by any intelligent stenographer and doctors who are being used for executive work that could be done by laymen are not being trained; they are being wasted. Doctors lying around for lack of equipment should have been left in civilian life until the equipment was ready. Finally, thousands of doctors, according to doctors in the military service, are being used for medical work that utterly wastes their years of training as specialists. Orthopedists (bone specialists) examine recruits, surgeons sit at desks, nose and throat men do obstetrics or paper work. Some of this is in the process of correction, but the process is slowed by the wholesale recruiting of doctors before the Army and Navy have even half digested those already in the service.)"

Physicians have a Different Opinion of the Situation.—Members of the California Medical Association have been repeatedly informed concerning the need for adequate medical personnel for the armed forces by the United States Army and Navy, through the official and other notices appearing in the *Journal of the American Medical Association* and CALIFORNIA AND WESTERN MEDICINE. The California Procurement and Assignment Service (Dr. Harold Fletcher, San Francisco, chairman, and Dr. Edward M. Pallette, Los Angeles, vice-chairman) has also kept the component county societies and physicians generally, in touch with immediate and prospective needs, and the status of California in the quotas assigned to the States of the Union.

The opinions expressed by the *Examiner* may be shared by a limited number of individual physicians, but there is nothing on record to indicate that they are accepted by the great majority of physicians of California, in either military or civilian service.

* * *

An Illuminating Letter from the War Manpower Commission's Procurement Division.—Perhaps the best answer to the *Examiner's* statements may be found in a letter received while the above comments were being sent to the printer. The communication, dated May 6, 1943, comes from President Roosevelt's War Manpower Commission and is signed by Doctor Frank H. Lahey, recent president of the American Medical Association who, as chairman of the Directing Board of the national Procurement and Assignment Service, is in possession of facts and figures that permit him to speak with authority. Doctor Lahey's letter follows, the attachments with statements by the Surgeon Generals of the United States Army, Navy and Public Health Service appearing in the War Effort Department in this issue (on page 281):

(COPY)

WAR MANPOWER COMMISSION
Office for Emergency Management
Procurement and Assignment Service for Physicians, Dentists, and Veterinarians
Washington, D. C.

May 6, 1943.

Dear Doctor Kress:

Attached are statements pertaining to the procurement of physicians to meet the nation's military and civilian needs, prepared by the surgeons general of the Army, Navy and the U. S. Public Health Service, and the chairman of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians.

The failure of some areas in the country to provide their quota of physicians for the armed forces reflects unfortunately on all of American medicine. Is American medicine incapable of making the sacrifices required of it without compulsion?

We must face one inescapable fact. Our fighting men, and those who must remain behind, must and will have medical care. It will be obtained one way or another. The choice of methods is still in our hands. The medical profession of this country never has failed the nation: it must not do so now!

The Directing Board of Procurement and Assignment Service seeks your further aid in the recruiting task that is before us by requesting that you publish in the next issue of CALIFORNIA AND WESTERN MEDICINE the four statements that are attached. (Editor's Note. The four statements appear in this issue in the department of the California Committee on Participation of the Medical Profession in the War Effort. See page 281.)

An editorial in the same issue calling attention to these statements and some of the considerations referred to in this communication, also would be most helpful.

The Directing Board is most grateful for the aid you already have extended them and for that which it knows you will continue to extend.

Very truly yours,
(Signed) FRANK H. LAHEY, M. D.,
Chairman, Directing Board.

EDITORIAL COMMENT†

DEPOLYMERIZED ANTIBODIES

The first recorded instance of a specific antibody definitely increased in titer by chemical alteration of serum proteins is currently reported by Eggerth[1] of the Department of Bacteriology, Long Island College of Medicine.

Antibodies have been previously modified by various chemical agents, such as acids, alkalies, formaldehyde, or by combination with diazo compounds. Such modifications have almost invariably reduced specific titer or destroyed one or more of the specific reacting properties. Thus Eagle[2] found that one part of formaldehyde in 1,000 parts of diphtheria antitoxin would completely inhibit its flocculating activity, without reducing its therapeutic titer. Weil[3] treated antibodies with acids and found that they had lost most of their ability to fix complement. Antibodies have also been modified by partial digestion with pepsin,[4] trypsin[5] or other digestive enzymes. Coghill,[6] for example, partially digested diphtheria antitoxin with Taka-diastase, and thus prepared a therapeutically effective "refined antitoxin" whose original horse specificity was so altered that it no longer gave anaphylactic reactions on injection into guinea pigs previously sensitized to native horse proteins. This he interpreted as indicating that part of the antibody-molecule is immunologically inert, and that the functional portion is practically unaltered by such partial digestion.

Ninhydrin has been used for a generation for the qualitative and quantitative determination of amino groups. Its method of action on serum proteins has been fairly well determined. In his earlier work Eggerth[7] found that while ninhydrinized antityphoid horse agglutinins had lost about

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

45 per cent of their original amino nitrogen and were no longer coagulable by heat at reactions higher than pH 5.5, they often retained their full agglutinating titer. Since then ninhydrinization has been applied to rabbit serums. In his latest technique, antityphoid rabbit serum is dialysed against a phosphate buffer solution, and the serum "dilated" to three times its original volume with the same buffer. One volume is freshly prepared 1 per cent ninhydrin solution in distilled water is then added and the mixture incubated for two hours or more at 37°C. The protein precipitate that forms on this addition may either be removed and the serum fractionated, or retained and eventually redissolved by dialysis against distilled water.

In a typical experiment a rabbit serum having an original typhoid H-agglutinin titer of 1:10,000 had its titer increased three-fold by the end of 30 minutes of this incubation, and further increased to 1:40,000 (four-fold) by the end of 2 hours. Incubation for 18 hours reduced the titer to the 30 minutes three-fold level (1:30,000). Every rabbit antiserum thus far tested showed this increase, though not always to the same degree. The serum showing the greatest increase was from an animal that had been under periodic immunization for over a year. On fractionation of the ninhydrinized serum most of the H-agglutinin was demonstrable in the "salt-soluble portion of the acid precipitate." This portion contained only 14 per cent of the original serum proteins. While the original untreated immune serum contained 1,100 H-agglutinin units per mg. of total N, and the 30 minutes ninhydrinized whole serums contained 3,300 such units, the salt-soluble fraction contained 16,000 units per mg. N.

Isolation of the active principle of immune serums by a saltingout process is of course not new. The remarkable increase in antibody titer per mg. of total N as a result of ninhydrinization, however, is a phenomenon not previously described. Eggerston suggests four plausible hypotheses to account for this increase, the simplest being an assumed depolymerization or breaking down of large natural antibody aggregates into simple units, thus increasing the number of active molecules. Whether or not this theory is confirmed, the possibility of improving natural antibodies by simple chemical modification opens up a new field of immunochemical research of almost unlimited clinical promise.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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SPLENIC STREPTOLYSIN

Isolation of a splenic component with a high specific bactericidal action on hemolytic streptococci is currently reported by Nutini[1] and his coworkers of the Institutum Divi Thomae, Cincinnati, Ohio.

Autopsy spleens showing no gross pathological lesions were thoroughly minced and alternately frozen and thawed 3 times in an equal volume of Drew's solution. The material was passed through a Büchner filter, the filtrate centrifuged and the sediment discarded. To the clear supernatant fluid 95 per cent alcohol was then added periodically over an interval of several days to produce a final alcoholic concentration of 80 per cent. The secondary precipitate thus formed was filtered out and discarded. The resulting clear alcoholic solution was concentrated in vacuo at 30°C to the original volume of the Drew's solution and was then sterilized by passage through a Seitz filter. The resulting sterile filtrate was then evaporated to dryness, to get rid of traces of alcohol. The yield was about 2 g. of solid material per 100 grams of spleen. Solid material corresponding to 0.5 per cent of the Drew's extract added to 20 c.c. of beef-heart infusion agar completely inhibited the growth of all strains of hemolytic streptocci. Similar streptolytic titers were obtained with extracts from bovine spleens. Control tests showed no bactericidal effects of the human extract on pneumococci, staphylococci, or E. coli, indicating that the splenic bacteriolysin is at least relatively specific for streptococci. Since the active principle in this extract is thermostable and is not precipitated by 80 per cent alcohol, Nutini believes it is an entirely new immunity substance differing from the lysozymes and bacteriostatic enzymes of previous investigators.

Work is now in progress on the toxicity of the new splenic extract and its therapeutic efficiency on streptococcus infected animals.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

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MEDICAL EPONYM

Sibson's Groove

Francis Sibson (1814-1876), while resident surgeon and apothecary to the Nottingham General Hospital, published a paper, entitled, "On the External Signs of the Position of the Lungs and Heart," in the *London Medical Gazette* (6:754-760, 1848). A portion of the article follows:

"In the healthy robust man the well-formed chest has certain prominences and depressions indicating the organs underneath. . . . A depression crosses the seventh and sixth costal cartilages from the lower end of the sternum to the fifth intercostal space. These depressions are just below the thoracic prominences; the right depression exactly indicates the lower margin of the right lung, while the left depression indicates the lower boundary of the heart."—R.W.B., in *New England Journal of Medicine*.

ORIGINAL ARTICLES

Scientific and General

TRAUMATIC SHOCK AND HEMORRHAGE*

L. A. Alesen, M. D.
Los Angeles

SHOCK is a condition more readily described than defined. It may result from any one or more of a number of different causes—trauma, hemorrhage, burns, infection, exposure — but from whatever cause produced, the ultimate condition is characterized by decreased blood volume and volume flow, diminished cardiac output, arteriolar vasoconstriction, hemoconcentration, capillary dilatation and congestion, increased capillary permeability, and secondary fall of blood pressure. Other related factors, which usually accompany shock and serve to perpetuate and aggravate it, are deficient oxygenation or anoxia, hyperpotassemia, and deficient adrenocortical hormone.

RÔLE OF THE CAPILLARIES

Since the pathological and clinical features of shock, or peripheral circulatory failure, are due, in the last analysis, to deranged capillary function, and since the successful treatment of shock from whatever cause produced is directed towards restoring the fluid lost as the result of this deranged capillary function and, at the same time, improving that function, it is appropriate to direct attention to the capillaries as the fundamental unit involved.

The capillaries are finely-spun tubules consisting of a single layer of endothelial cells which constitute a semipermeable animal membrane. There are no smooth muscle or adventitial layers; however, special methods show the presence of the Rouget cells surrounding the capillary walls. These are cells of rather large nuclei and many thread-like fibrillary processes, which intertwine with each other and form a network around the capillary. These cells are thought to be of smooth-muscle origin and to produce capillary contraction. While there is undoubtedly some central nervous system control over their activity, it is pretty well agreed the capillaries possess a large degree of independent tonus and contractility.

The function of the capillaries is to provide a channel through which oxygen and nourishment may reach the tissues, and through which the waste products of metabolism may be discharged. In health, a fine balance between intravascular contents, tissue space and intracellular contents is maintained by several physical factors operating upon this semipermeable animal membrane which is the capillary endothelial wall. The intraarteriolar hydrostatic pressure is sixty millimeters of mercury. The osmotic attraction of the contained plasma protein, which is normally about seven per cent of the total plasma, is approximately forty millimeters of mercury, thus leaving a positive filtration pressure within the capillary wall of about twenty millimeters of mercury. On the venous side, the osmotic attraction of the contained plasma protein is about forty-five millimeters of mercury and the hydrostatic pressure ten millimeters, thereby leaving an osmotic attraction pressure of thirty-five millimeters of mercury. Under normal conditions, water, crystalloids and metabolic products pass back and forth over this animal membrane rather freely, but the larger protein molecules and the cellular elements of the blood pass with difficulty, if at all. The chief function of the plasma protein is to maintain the essential osmotic pressure within the capillary lumen at all times.

Some idea of the vast potential capillary bed may be gained by the statement that in the skeletal muscle of a man of normal size, the capillaries are approximately one hundred thousand kilometers in length, and have a total surface of sixty-three hundred square meters. Within these capillaries one cubic centimeter of blood is in contact with five to seven thousand square centimeters of capillary surface, thus providing the immediate proximity essential for the physiological exchange of nutriment and waste products.

Krogh[9] has shown that this vast capillary bed may contract and expand in response to physiological requirements or abnormal conditions. Lewis,[10] Moon[11] and others have demonstrated that the independent tonus and contractility of the capillaries respond promptly to trauma, thermal changes, chemical substances, deficient oxygenation and products of metabolism.

During normal physiological activity, such as muscular work, the products of metabolism affect the capillaries directly, causing them to dilate and thus permit an increased delivery of nutrition and oxygen, and an increased removal of waste products. But this physiological dilatation of the capillary is not accompanied by any increased or abnormal permeability of its wall.

The work of Moon[11] has been fundamental to an understanding of the mechanism of histamine shock and an explanation of the basic importance of capillary response in all forms of peripheral circulatory failure. Histamine, acetylcholine, as well as many other chemical substances, when introduced in small amounts under the skin cause a local capillary dilatation together with increased permeability accompanied by the development of a typical wheal. Moon[11] calls the wheal "shock in miniature." If sufficient capillary damage is done by this chemical injury, loss of intravascular fluid, water, plasma, and some cellular elements occurs, thus giving the typical picture of inflam-

* Read before the General Meeting, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Department of Surgery, College of Medical Evangelists, and the Surgical Service of the Los Angeles County General Hospital.

mation. This same picture is produced by bacterial poisons, physical agents, such as trauma, burns, or freezing. If now, histamine, acetylcholine, bacterial poisons or other toxins in sufficient quantity are diffused generally throughout the entire circulation, there is a widespread capillary damage with its resultant dilatation, increased permeability to plasma protein and its progressive tendency to form the complete picture of shock as first described. Thus, Moon[11] places great emphasis upon an "H-Substance" or histamine-like substance, in the explanation of all forms of shock. This H-Substance merely aggravates a normal physiologic mechanism into an exaggerated or pathologic response.

PATHOGENESIS OF SHOCK

1. Toxemia Theory. — As previously stated, Moon[11] explains the initiation of all shock upon the activity of an H-Substance which may be elaborated by the effect of trauma, heat or cold upon the body cells, by the deprivation of oxygen due to hemorrhage, or by action of bacterial or other poisons. Marked dehydration, as occurring in prolonged vomiting or diarrhea, acute infections, as pneumonia or typhoid fever, produce shock by their toxic effect on capillary endothelium. Whether or not his theory is in all respects correct, it is fundamental in that it places chief importance upon the capillaries as the basic pathologic unit in shock.

2. Theory of Nociceptive Nervous Stimuli.— O'Shaughnessy and Slome,[12] as the result of many experiments on cats in which the nervous impulses were interrupted by section of the nerves to the limbs and section and destruction of the spinal cord before the limbs were traumatized, found that the shock syndrome so produced was less severe than in the control group. They state, "we regard the two remaining factors, local fluid loss and the discharge of nociceptive nervous stimuli, as the effective etiological agents. The evidence does not allow us to dogmatize as to the relative importance of these factors, although we are inclined to believe that the nervous factor dominates the picture." Blalock[3] states: "The experimental evidence thus far indicates that nerve impulses are at least secondary in importance to the local loss of fluid in the initiation of shock which results from severe trauma to an extremity."

3. Suprarenal Hyperactivity and Hypoactivity. —Experimentally, Bainbridge and Trevan,[1] and Erlanger and Gasser[5] have produced vasoconstriction and shock by injection of adrenalin. They noted marked engorgement of the capillaries and venules of the intestinal villi. While vasoconstriction is doubtless an important accompaniment in most forms of shock, evidence seems to indicate that vasoconstriction alone is not sufficient to produce the typical syndrome of peripheral circulatory failure. Vasoconstriction is a protective mechanism to maintain adequate blood pressure for the vital centers in the face of decreasing blood volume. The failure of the adrenocortical hormone is probably of greater significance in the sustaining and aggravation of shock. Scudder[13] emphasizes this deficiency, particularly with reference to its control over potassium metabolism. He finds plasma potassium very much increased in practically all shock states, and considers that hyperpotassemia is one important factor in furthering capillary dilatation and permeability.

4. Local Loss of Blood and Fluid Theory.— Much experimental work has been done with particular reference towards determining the importance played by local loss of blood and fluid in the production of shock. Parsons and Phemister,[15] Blalock[4] and Bradburn, Beard[2] and Blalock, Hawkins and Harmon, and many others have contributed to this phase. Chemical analyses of the fluid which accumulates as result of trauma or burns in regions of the areas injured have shown that this fluid has essentially the same composition as the plasma of the blood, containing very few erythrocytes. The protein content is practically identical with that of plasma. In all these types of trauma, large quantities of plasma were lost and hemoconcentration was marked. Mann found similar results in experimental work on intestinal trauma. Blalock[3] states: "In summary, it is my impression that the local loss of fluid at the site of injury is sufficient in many instances of shock to account for at least part of the decline in blood volume and for some of the associated alterations. In other words, it is the most important initiating factor, not in all but in many instances of shock."

Those who hold to the local fluid loss theory as the most plausible explanation for the initiation of shock—and this is pretty generally the consensus of opinion at this time—stress the effect of the vicious cycle in its maintenance and aggravation. This vicious cycle has been well diagrammed by Moon.[11] Thus, to Moon, who favors the traumatic toxemia theory, the capillary is primarily damaged by an H-substance causing its dilatation and increased permeability with resulting loss in plasma protein, hemoconcentration, decreased blood volume, reduced cardiac output, arteriolar constriction, and capillary congestion. This condition is further aggravated by tissue anoxia which still further damages the capillary endothelium and ultimately results in the condition of irreversible shock, in which capillaries are irreparably injured and no amount of treatment is of any value.

Those who hold to the physical fluid loss theory recognize the vicious cycle initiated by plasma loss producing lowered osmotic pressure, increased capillary permeability with hemoconcentration and anoxia. So, regardless of which factor is of prime importance in initiating the shock, all are agreed that its fundamental manifestations are mediated through capillary damage.

CLASSIFICATION OF SHOCK

While there are many classifications of shock, some of them quite elaborate, it is sufficient for clinical purposes to divide the condition into (1) primary or neurogenic and (2) secondary or hematogenic.

Primary or neurogenic shock is synonymous with syncope or collapse. This may be brought about by emotions such as fright, or may occur during abdominal exploration in the region of the diaphragm. It occurs in spinal anesthesia. Goltz explained primary shock by demonstrating that a blow on the exposed mesentery of a frog caused reflex inhibition of the heart through the vagus and a lessening of vascular tone throughout the body, especially in the splanchic area. Primary, or neurogenic, shock is of short duration, and is characterized by peripheral vasodilatation, warm extremities and a slow pulse.

Secondary, or hematogenic, shock may follow primary or neurogenic shock immediately, but the onset of secondary shock is usually somewhat delayed and its clinical characteristics are quite different.

CLINICAL PICTURE

The clinical picture of well-developed secondary or hematogenic shock is familiar to all. The patient is pale, ashy gray; the extremities are cold; the pulse is rapid, thready; the blood pressure, which at first may be maintained fairly well, is characterized by decreased pulse pressure and a systolic pressure that falls more rapidly than the diastolic. The respirations are not labored. Muscular twitchings are common. Hipprocratic facies are frequent, and a stupor or delirium may be present. The diagnosis of hematogenic shock or peripheral circulatory failure is usually quite obvious. It is to be differentiated from acute failure of the heart. This commonly presents little difficulty. In acute failure of the heart, there is venous distention due to overfilling of the vascular bed, whereas shock is characterized by collapsed veins due to underfiilling of the vascular bed. Rapid and progressive enlargement of the liver, subcutaneous edema, pulmonary congestion evidenced by dyspnea, cough, râles at the lung bases, all point toward acute heart failure. The presence of a peritonitis, intestinal obstruction, or other etiologic factors of peripheral circulatory failure is readily contrasted with the manifestations of coronary thrombosis or pericardial fluid. The blood pressure alone is not a reliable indication in either condition.

The differentiation between peripheral circulatory failure due to hemorrhage and that due to trauma, burns, toxins, or any other cause is of more academic importance than of real clinical value. For, with the exception of the rapid exsanguination due to the injury of a very large vessel, the mechanism of death from hemorrhage is identical with that of death from other forms of shock, that is, "A progressive vasoconstrictive oligemic anoxia" (Harkins[8]). More will be said about the differentiation of shock due to hemorrhage and to other causes under the heading of treatment.

TREATMENT

It is axiomatic, obvious and trite to state the best treatment of traumatic shock and hemorrhage is their prevention. Under actual conditions of warfare, it has been found that a soldier is much more resistant to shock if he is well clothed in warm dry garments; if he is well fed with nourishing food containing an ample supply of vitamins, particularly vitamin C. Further, it is important to allay pain by the administration of opiates, by the prompt and efficient splinting of fractures, stop hemorrhage, prevent infection by the application of sterile dressings without chemical antiseptics, to immobilize wounds and to perform necessary procedures such as wound excision and debridement as soon as possible after the casualty occurs and before secondary shock supervenes.

Needless to say, operative procedures should be done deftly, promptly, and with no unnecessary handling of tissues.

Anesthesia.—Some authors express a preference for cyclopropane because it is administered with large quantities of oxygen. Others favor ether. There is some experimental evidence to indicate that sodium amytal is of value in minimizing shock.

Open pneumothorax should be closed by sutures or adhesive dressings. Tourniquets should be used only if bleeding cannot otherwise be controlled, and should be released each hour. Warm fluids, external heat, are of value, but excessive heat should not be used because of its tendency to aggravate capillary dilatation.

Vasoconstrictor drugs, such as epinephrine, ephedrin, caffeine, camphor, strychnine, coramine, benzedrine are absolutely contraindicated in secondary or hematogenic shock. They have some value in the treatment of primary or neurogenic shock. Pitressin may be found to be useful for its specific effect of causing a constriction of the capillaries and a decrease in their permeability.

Active Treatment. — The active treatment of secondary shock may be concisely stated as having two purposes: First, the replacement of fluid that has been lost and, second, the prevention of further fluid loss. The injured capillary, with its dilatation, increased permeability, leaking plasma, and concentration of cellular elements, is the direct object of therapeutic attack. Scudder's[13] excellent work in this field is a guide to efficient replacement and arrestive treatment. He stresses the necessity of considering not only the degree of hemoconcentration, but the degree of dehydration, and the level of plasma potassium. He finds that almost universally, in cases of shock and hemorrhage, there is a marked increase of the plasma potassium, and this factor he considers

of great importance in the vicious circle of shock. To Scudder the shock of Addisonian crisis, or that occurring in adrenalectomized animals, is essentially the same as shock occurring from other causes, and he feels this serves an important basis for the treatment of all conditions of shock.

The work of Gamble, Ross and Tisdal[6] on body fluids has shown that the chief base of blood and extracellular fluid is sodium, while potassium is the chief base of intracellular fluid. In shock states it is believed that intracellular potassium becomes extracellular potassium through adrenocortical failure, thus aggravating vasoconstriction and capillary damage.

Normal Values:

Cell Volume (Hematocrit):
Males—46 per cent, with a range of 42-50.
Females—average 41 per cent, with a range of 39-43.

Specific Gravity of Whole Blood:
Males—average 1.0566.
Females—average 1.0533.

Specific Gravity of Plasma:
Average for both sexes—1.0270. (The purpose of estimating plasma specific gravity is chiefly that it gives a rapid method of determining plasma protein.)

Plasma Protein: Approximately 70 grams of protein for each liter of plasma, variations between 5.9 and 6.9 grams per cent.

Plasma Potassium: Normally seventeen milligrams per hundred c.c.

Conversion Values:

Red Blood Count	Hemoglobin	Hematocrit Per Cent Cells	Specific Gravity of Blood
0	0	0	1.0300
1.000 000	20	10	1.0350
2 000 000	40	20	1.0400
3 000 000	60	30	1.0450
4.000 000	80	40	1.0500
5 000 000	100	50	1 0550
6,000,000	120	60	1.0600

Characteristic findings in specific conditions:

Hemorrhage.—Early following hemorrhage of moderate or considerable degree, there is usually hemo dilution, characterized by lowered hematocrit (cell volume) reading, lowered specific gravity of whole blood and plasma, lowered hemoglobin, and lowered red blood count.

Simple dehydration.—This represents actual acute water loss. It is found in conditions in which there are excessive vomiting, severe diarrhea, diminished fluid intake.

There are found hemoconcentration, increased specific gravity of the blood and plasma, and increased red cell and hemoglobin determination.

Shock.—This represents varying degrees of water, protein, and whole blood loss, depending upon the causative factor. There is definite hemoconcentration, as represented by the increased hematocrit readings, increased hemoglobin and red blood cell determinations, and there is decreased plasma protein. In most, if not all, of these conditions as emphasized by Scudder, there is a definite increase in the plasma potassium whose normal value is 17 milligrams per hundred c.c. of plasma.

In simple dehydration which has not progressed to the extent of true shock with plasma and protein loss, the administration of crystalloids, such as glucose in normal saline, is logical and effective. The progress of the patient under these conditions should be carefully checked by further determinations of the plasma protein, to make sure that the crystalloid solutions thus introduced are not washing out the needed plasma protein through damaged capillary endothelium.

It cannot be too strongly emphasized that hypertonic solutions of crystalloids in themselves are considered, by most observers, to be absolutely contraindicated in the treatment of full-blown secondary shock. Scudder, however, believes that the use of five per cent sodium chloride solution is indicated in the treatment of shock as an adjunct to the use of blood plasma, or serum, for the reason that it serves to counteract the effect of excessive plasma potassium, which factor he feels is of importance as a positive H-substance in aggravating capillary damage. His findings have not been widely confirmed, but his published results in the use of this therapy seem excellent.

In peripheral circulatory failure, obviously due to hemorrhage, the use of whole blood, either fresh or preserved, would seem to be the method of choice. However, even in hemorrhage, it is rarely the loss of blood itself that causes death, but the secondary shock syndrome which is responsible for the fatality. Therefore, with the hemorrhage arrested, plasma or serum are quite suitable.

Secondary Shock.—In all instances of secondary shock, regardless of their origin, plasma or serum is the ideal method of treatment. This is directed at restoring the normal values of plasma protein, which is responsible for the osmotic pressure which in turn maintains normal blood volume. There has been much controversy in the past over the relative merits of plasma and serum. Those who oppose plasma contend that the introduction of citrate to prevent clotting, together with the fibrin veil, are objectionable features. Those who object to serum state that its administration is more apt to be accompanied by reactions. These reactions are explained on the basis of the production of vasoconstrictor and vasodilator substances during the mechanism of clotting which removes fibrin. Volume for volume, plasma and serum are of approximately equal value in restoring osmotic pressure. Both plasma and serum may be stored in sterile containers at room temperature indefinitely. They may both be dried by any one of several desiccating processes and stored, transported, and used with the addition of distilled water or normal salt upon an instant's notice. The advantages of plasma and serum administration are many and obvious. Pooled plasma or serum is used without typing, because the isoagglutinins are thus neutralized.

COMMENT

The most common mistake made in treatment of these patients is failure to give sufficient plasma or serum. As a rough rule of thumb, it may be stated that 100 c.c. of plasma are required for every point of hematocrit reading above 45 per cent. But, there are no cook-book rules whereby treatment may be reduced to mathematical precision. Careful clinical observation of the patient, repeated check on hematocrit, hemoglobin, specific gravity, plasma protein are all essential if success is to be obtained. In shock whole blood is contraindicated because it adds more cellular elements to an already congested capillary bed. However, British authorities state that when three or more pints of plasma are required, one in three should be whole blood.

The second objective of treatment, that is, the restoration of the damaged capillary endothelium to a normal state in order to prevent further fluid loss into the tissue spaces, is the most difficult to achieve. The two chief remedies at present available for this purpose are oxygen and adrenocortical extract.

Oxygen should be given, in 100 per cent concentration, by the BLB mask. In this manner, much may be done to prevent anoxia which is one of the important sustaining factors in capillary damage. It may be continuously administered in this way for 48 hours without danger. Adrenocortical extract in doses of from ten to twenty c.c. in the form of Eschatin intravenously or intramuscularly seems indicated both from the standpoint of clinical results and from theoretical considerations inasmuch as this cortical extract is believed to decrease capillary permeability and also to decrease hyperpotassemia. Scudder is particularly enthusiastic over the use of large doses of eschatin intravenously, together with five per cent sodium chloride as an adjunct to plasma or serum, but he emphasizes the necessity of accurate laboratory control for all of these measures.

Hyland[16] states that the plasma albumin is responsible for 80 per cent of the osmotic pressure of the plasma protein, and that its preparation in a comparatively pure form by precipitation of the globulin by ammonium sulphate may offer in the future a more accurate means of treating the hypoproteinemia due to shock. Other investigators have studied the possible use of bovine albumin, but their results are as yet too contradictory to be reliable for clinical use.

IN CONCLUSION

Traumatic or wound shock and the syndrome of shock or collapse consequent upon hemorrhage are but two manifestations of peripheral circulatory failure, the basic factor of which is a damaged capillary endothelium with dilatation and abnormal permeability accounting for all of the symptoms involved. Treatment should be directed toward prevention as far as that is possible; toward early replacement of lost blood volume by the essential proteins, and toward the restoration of the damaged capillary endothelium to as normal a state as possible.

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DERMATOSES: THEIR LOCAL TREATMENT WITH SULFATHIAZOLE AND SULFADIAZINE*

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NEARLY all diseases under my observation, where a pyogenic element could be suspected, were approached on the assumption that most skin diseases present a symbiosis of various staphylococcus and streptococcus cultures, besides the essential fundamental characteristics pertaining to each disease. This having been undertaken during the last year, prior to this date, sulfathiazole would be the first to be tried out. Stimulated by various inciting reports of impetigo treated with the sulfa drugs, the beneficial influence on this disease group was first rapidly confirmed.

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Current literature on the topical use of sulfathiazole is still scant. However, L. Keeney,[1] et al., treated sixty-nine patients with sufathiazole incorporated in salves, five per cent. He had more or less striking results, particularly in secondarily infected eczema, seborrheic dermatitis, impetigo, acne vulgaris, mercurial folliculitis and furunculosis. They noticed no toxic effect, and, even when the salve was applied over half the body, the blood concentration varied roughly from 2.0 to 3.5 milligrams per 100 c.c. of blood. In limited areas no traceable concentration could be detected. The physical well-being improved quickly after the application, from immediately afterwards until from one to two weeks.

H. M. Robinson and H. M. Robinson, Jr.,[2] observe the same dramatic improvement, but take the exception that it is valueless in epidermophytosis, contact dermatitis, as well as in other dermatoses.

For the rest, extensive reports deal with the oral administration in various dermatoses. This article deals only with the topical applications. The oral administration of sulfathiazole, et al., being left out entirely, has some bearing on oral administration of sulfathiazole only as far as sensitivity reactions go. Since some of my patients did come under observation where previous oral sulfa drug medication had resulted in skin reactions and (by omission of information), subsequent applications of sulfa drugs were given, severe local reactions were invariably seen; the physicians in charge being without blame for these mistakes.

AUTHOR'S OBSERVATIONS

After a more cautious approach, I expanded enthusiastically to various types of diseases connected with mixed staphylococcus-streptococcus infection as a primary causative factor, or, secondly, as an additional acquired factor. All together about three hundred cases have been approached this way and only by external medication—no oral medication. Sulfathiazole was used first, and, during the last two months, sulfadiazine. The drugs were incorporated in salves, powders and paints; in the same way any other ingredient would have been incorporated in the disease to be treated. For example: salves for psoriasis, powder or paint for intertriginous eczema and so forth. The concentration of sulfathiazole in salves and lotions was kept constantly at three per cent, and in powders, five per cent; for sulfadiazine, three per cent, and in exceptional cases, four per cent in salves and powders. Both were applied twice a day with specific instructions for the patient to clean the skin with oil before applying.

DISEASES UNDER TREATMENT

The following is a list of the diseases treated: Impetigo, Folliculitis, Sycosis Barbae, Dermatitis Venenata, Poison Oak, Acne Vulgaris, Cystic Acne, Acne Rosacea, Boils, Abscesses, Stasis Dermatitis, Neurodermatitis, Intertriginous Eczema, Herpes simplex, Herpes zoster, x-ray ulcer, Epidermaphytosis, Seborrheich dermatitis, Perleche, Paronychia, Monilia infection, Psoriasis, Lichen Planus, Lupus Erythematosus, Pemphigus, Darrier's Disease.

Since it was felt that here was an enormous field opening up, I need not ask excuse for having employed it in so widely different diseases as impetigo and infectious eczema up to such impossible probabilities as psoriasis. In the latter it was assumed that sulfathiazole might be a photosensitizer, and that exposure to ultra violet light at the same time as the applications were given would enhance the effect of ultra violet light. (This, however, did not materialize.)

I reserved the investigation for my private cases. A certain number which were treated at Stanford Medical School, Dermatological Clinic, responded quite well, although they are not included in these tabulations.

Because the applications were used over a limited area, no blood estimates were taken, since only extensive use of both drugs gave traceable blood concentrations.

TABLE 1.—*Local Treatment of Dermatoses with Sulfadiazine and Sulfathiazole*

Disease	*Cases*	*Average Days Healing Time*	*Sensitivity*
Impetigo	15	8	2
Folliculitis	54	7	
Sycosis Barba	6	8	
Dermatitis Venenata	51	11	
Poison Oak	*	*	
Acne Vulgaris	35[2]	7 to 14	2
Cystic Acne	9[3]	10	
Acne Rosacea	6	7 to 14	1
Boils, Abscesses	15		
Stasis Dermatitis	15	15	
Neurodermatitis	9	8	1
Intertriginous Eczema	12	6	
Herpes Simplex	*	*	
Herpes Zoster	2	prompt	
X-ray ulcer	3	prompt	1
Epidermophytosis	15	prompt	1
Seborrheic dermatitis	30	7 to 14	1
Perleche, etc. (Paronychia, Moniliasis)			
Ulcers	*	*	
Psoriasis	4[1]		
Blistering Burns	*	*	
Lichen Planus	2[1]		
Lupus Erythematosus	2[1]		
Pemphigus	1		
Darrier's Disease	1		

*Inconclusive—10% or less.
[1] No Response. Response: 75-80%.
[2] Improvement 50%. Did not Return: 28-8%.
[3] Improvement 30%.

COMMENT

It will be seen that some of the diseases offered for treatment with sulfathiazole and sulfadiazine responded well, and in a dramatic and encouraging way. Obviously, it is difficult or impossible to classify in detail the conditions and concommittant situations in this treatment group. Coöperation, comprehension and willingness to carry out the instructions given are all deciding factors; and, last but not least, comes the cutaneous sensations which will aggravate and impede healing ad

infinitum unless the treated parts are protected in some or other way. I beg, therefore, that these data not be interpreted too literally, but with a broad understanding. Taken as a whole, the treatment was easy to carry out ambulatory.

I can fully subscribe to the optimistic view regarding *impetigo* treated with sulfathiazole. My average of eight days could easily be improved to a much shorter period depending upon what type of case was to be treated. Usually the general condition and hygiene (management by the patient) were all-important factors as well.

As would be expected, *folliculitis and sycosis barba* responded dramatically. An average of seven days for the prevention of new lesions to appear as compared with the weeks', and often months' duration of such lesions to other measures, makes sulfathiazole a drug of choice. Certain cases of sycosis barba will respond as dramatically as impetigo if other measures are considered as well. One recalcitrant case had to be approached by other means. I believe the régime and handling, correct management of these severe cases is all important as well, besides the applications of sulfathiazole. Naturally, there will be cases which do not respond because of voluntary or involuntary mechanical friction, apposition of skin folds, discharge from sinuses, and so forth, which will handicap the quick cure.

Stasis dermatitis, especially where there is any amount of secondary infection, healed up in an average of fifteen days, in sharp contrast to the month-long treatment which any other régime will require. In this series is included weeping, raw forms, excluding outright ulcers. A fifty-five year old gentleman with elephantiasis-like swelling of the left leg and varicosities will long be remembered. The leg was secondarily infected and enormous verrucuos proliferations had deformed the entire leg and foot completely and incapacitated the patient, who was bedridden. In two months, during which three per cent sulfathiazole in cold cream was applied (plus bed rest), the leg resumed its gradual normal proportions, and the patient seemed as impressed as the attending nurses and myself were. The beneficial effect of the sulfathiazole applications in this form of dermatitis can be warmly recommended, and could be employed as salves, wet-packs or powders, depending upon the amount of weeping and ulceration which would follow. The lack of response in severe cases was mostly caused by other elements not pertaining to the pyogenic elements.

Dermatitis venenata, counting all types from the more severe to the lightest ones, healed up in an average of eleven days. At first thought this would not seem very striking as compared with other methods. Naturally, there are some cases which would heal up just as fast or faster under ordinary methods like mild, antiseptic wet-packs. However, long-standing and severe industrial cases, and the severe secondary infection often associated with these cases respond extremely favorably. These patients did not offer great incidence of sensitivity to sulfa drugs.

Certain types of *seborrheic dermatitis,* next, healed up so dramatically that I almost resent that an average of seven days for the common seborrheic dermatitis, including seborrheic dermatitis of the eyelids, may sound rather optimistic. In the judgment, I have not included heavy, chronic cases where multiple elements such as neurodermatitis, impaired nutrition and circulation, mechanical factors and so forth, played in.

Nevertheless, seborrheic dermatitis of the eyelids is another field with improved aspects. From oral communications, I gathered that cases which were always referred to dermatologists, now by contrast are treated with more confidence by the opthalmologist. Previously, a rigid and severe régime, wet packs, and possible hospitalization were required, whereas, now, most cases will respond to the sulfathiazole and sulfadiazine treatment almost "overnight."

Contrary to other reports, I feel that seborrheic dermatitis of the scalp is rather irresponsive, particularly combined with "neurodermatitis" in the nape of the neck. This condition requires more severe and specific antiseborrheic measures in addition to the sulfathiazole treatment, if used at all.

Acne cases will naturally vary enormously in response because of the patient's habitus, anatomy of the skin and many other factors. So, when I say that the improvement was definite after twenty-three days, it has to be taken for granted that this only means an initial or adjuvant measure in the acne régime. Two or three cases would show a debatable improvement and, for the rest, they all showed some response. If this could be referred to other measures was not always easy to decide. It is a matter of fact that the full understanding of this complex disease will require a number of other approaches as well. I should say the greatest value of sulfathiazole is the intermittent use with other known topical applications in general measure. It can be safely stated that a few "not quite so good" responses received the finishing touch by the sulfa drugs. Peculiarly enough, sensitivity cases were most frequent in these series.

Furunculosis and abscess formation treated by local applications alone seemed to offer no definite advantage over other methods or applications in as far as the cure of the furuncles or abscesses go; but I do feel that it offers advantage in preventing spread of follicular lesions or formations of new furuncles in the surroundings. As a matter of fact, I believe the oral applications would be the method of choice.

Contrary to other reports, I feel that certain forms of *epidermophytosis* offer a field where sulfathiazole is of decided value, such as the secondarily-infected type, where there is weeping, eczematous and inflammatory changes, as found both in the feet, skin folds and free body surfaces (on this last site with the least effect). For the skilled skin specialist it will be to judge when the

time comes to discard the sulfathiazole and take advantage of fungicides. Misjudging the interplay of many conditions present at the same time, the average physician usually overtreats an epidermophytosis with strong fungicides and will have concomittant, irritative phenomena with secondary infection dominating the picture. Then sulfathiazole, employed at the right time, will outdo any previous methods. It seems safe to say that sulfathiazole and sulfadiazine should not be considered to be fungicides. In the groins and other skin folds, as in *pruritus ani and intertriginous eczema,* the soggy appearance of the skin, together with a certain amount of moisture and particularly weeping surfaces, are strong indications for an initial approach with sulfathiazole usually employed thinly in ointments. This seemed better than when incorporated in lotions or powders.

Last, but not least, I may add the use in an ointment base in *paronychia,* which is usually recalcitrant in all hitherto known methods. No case failed to respond immediately. I felt this disorder now could be approached with greater confidence, provided the usual preventative measures were taken, also considering the coöperation of the patient. This included temporarily staying away from moisture, handling pastry, etc.

In *hemangiomas and warts* treated with carbon dioxide application, where blister formation will usually invite infection, the ulcers progressed naturally and quickly to healing. Any infected hemangioma will tolerate sulfathiazole applications in the form of salve on a gauze pad very well. The comfort to the child, and the lessened danger of septicimia, are weighty considerations, not to mention the easy handling of clean surfaces.

Other diseases, like herpes simplex, acne rosacea, poison oak dermatitis and pemphigus, will often respond with varying results. Here, also, many individual factors will play in. I feel, however, that pemphigus should be approached by topical applications with sulfathiazole or sulfadiazine; but having seen only one case respond favorably, I would not pass judgment. It would be invaluable as a protection against secondary invaders, especially in the latent stages with extensive, denuded, raw areas.

I mentioned the fact that sulfadiazine has been used by me the last two months only. I prefer not going into details, since it will complicate the picture and shall limit myself to the statement that there seems to be some advantage in using sulfadiazine, although instances could be quoted where sulfathiazole was better than sulfadiazine. On the other hand, I feel very strongly that the sensitivity reactions are less apt to occur with sulfadiazine. Of the whole series, ten cases of sensitivity to both sulfadiazine and sulfathiazole occurred. Without exception the sensitivity or dermatitis venenata which developed receded immediately on discontinuing the drug.

SUMMARY

Sulfathiazole and sulfadiazine offer themselves for a logical and discriminate topical application in dermatology, and have reduced the treatment period for primarily and secondarily infected skin diseases, vesicular and herpetic lesions, from one-half to one-third of the usual time in responsive cases. They usually prevent infections if applied early, causing nearly involution. An initial improvement, only, was observed where two or more conditions prevailed.

Sensitivity reactions were found to be relatively high (3.3 per cent), and parallel to the sensitivity reactions found in oral administration. One exception, where prolonged oral administration was tolerated, simultaneous local application gave severe sensitivity reaction. They present a decided danger, where occasionally an already critical and extensive dermatosis may be seriously aggravated.

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ANEURYSM OF THE RIGHT PULMONARY ARTERY

WITH RUPTURE INTO BRONCHUS; AND A PATENT DUCTUS ARTERIOSUS. REPORT OF CASE

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ANEURYSM of the trunk of the main branches of the pulmonary artery is rare. All investigators agree upon the rarity of this condition, as is established by post-mortem statistics from various sources. Jennis,[1] in 37,757 consecutive autopsies, found 1,671 aneurysms, none of which involved the pulmonary artery. According to Boyd and McGavack,[2] up to 1939 there were 139 cases reported, 30 of these with an antemortem diagnosis. Since their report, only four additional cases have been reported—Plenczner,[3] Duperie and de Lochand,[4] Reiner,[5] and Breslin, Solway and Eisen.[6] This case report makes a total of 144: 31 in which an antemortem diagnosis was made and proved by autopsy—present time June, 1942. The increasing number of antemortem diagnoses is due to progressive improvement in roentgenologic methods.

Age and Sex Incidence.—Sex has apparently little significance, since a few more cases were found in the female than in the male. Most writers agree as to the age incidence and Costa[7] has compiled the statistics in table form. (Table 1.)

Table 1.—*Incidence According to Age (Costa)*

Age	Aneurysm of aorta	Aneurysm of pulmonary artery: With malformation	Aneurysm of pulmonary artery: With infection	Aneurysm of pulmonary artery: Total
	Per Cent	Per Cent	Per Cent	Per Cent
0-30 years	12.0	28.5	9.5	38.0
31-50 years	62.0	15.8	23.8	39.6
Over 50 years	25.0	3.1	19.0	22.1

Of the cases, 38 per cent occurred under 30 years of age. This is in distinct contrast with aortic aneurysms in which only 12 per cent occurred under 30 years of age. Consideration of the table shows that in the majority of patients under 30 years of age aneurysms of the pulmonary artery are coincident with malformations, which explains the difference in age incidence between cases of aneurysm of the aorta and pulmonary artery. After the age of 50, there is no appreciable variation in age incidence between the two lesions. Accordingly, the analysis of age and sex incidence suggests that different etiologic functional and anatomic factors are operative in the two types of aneurysm.

ETIOLOGY

Boyd and McGavack conclude that increased pressure within the pulmonary circulation, plus arteriosclerosis are the chief etiological factors except where infection—subacute bacterial endocarditis—supervenes. Syphilis plays a less important part, contrary to the view of Warthin.[8] Rheumatic fever has been an antecedent factor. Trauma[9] also plays a rôle. Costa finds that in 46.5 per cent of all cases, some evidence of congenital defects can be found, the most frequent being a persistent patent ductus arteriosus (20 per cent).

Morphology.—The morphology has been well discussed by Costa, who observed that the trunk of the artery was the site of the aneurysm in 85 per cent of his cases. More frequently the condition was found nearer the valves than the bifurcation into the two main branches. Aneurysms are rarely found in the branches of the pulmonary artery (15 per cent), and less frequently in the right branch than in the left. Aneurysm formation is usually single, but multiple formation has also been reported. The shape is usually fusiform, but succiform aneurysms have also been reported. Dissecting aneurysms are rare, according to Neuburger.[10] The size varies from that of a nut to that of an orange, according to Lissauer[11] and Henschen;[12] while Perry[13] and others have reported very large aneurysms. The sac of the aneurysm is usually filled with lamellated clotted blood, which sometimes occludes the entire lumen of the artery. The wall of an aneurysm of the pulmonary artery is usually much thinner than that of an aneurysm of the aorta of the same size. The media and intima of the pulmonary artery offer little resistance to the blood pressure and are quickly destroyed.

CLINICAL FEATURES

The symptomatology of pulmonary aneurysm is by no means uniform, depending largely upon the coëxisting congenital anomalies. Boyd and McGavack, and Mason[14] enumerate dyspnoea, especially on exertion; cough, either dry or with sputum which may be blood-tinged; palpitation; precordial or substernal distress; sense of fullness in the chest and edema of the extremities. All or any of these may be encountered.

In the 30 cases of pulmonary aneurysm diagnosed clinically up to the present, the following were the most commonly observed physical signs: Prominence of the left side of the chest, especially in the second and third interspaces; with this were associated pulsation, occasionally a systolic thrill, impairment of resonance, and a harsh, sawing, systolic murmur in the same area. Groedel[15] states that these findings are inversely proportional to the amount of thrombosis in the aneurysm. Right-sided cardiac hypertrophy and dilatation may at times be found, but in the left ventricle are almost invariably absent. The electrocardiographic tracings may show right axis deviation. The roentgen ray is unquestionably of chief assistance in establishing a clinical diagnosis. Films should be taken in all standard positions. Fluoroscopic study is of extreme importance. The diagnosis is based on the marked prominence of the pulmonic arc on the left border of the cardiac silhouette which pulsates synchronously with the aorta when the latter is visible, or "see-saws" with the left ventricle, and which tends to obliterate the normal translucency of the "aortic window." In the presence of thrombosis of the aneurysm, pulsation may be diminished or absent. The differential diagnosis has been discussed by Boyd and McGavack, and Mason. Exitus by sudden death because of rupture of the aneurysm into the pericardium, or pleural cavity, or into the bronchus, occurs in approximately half the cases. The remainder die of congestive heart failure, or septic endocarditis.

REPORT OF CASE

Mrs. B. V. S., a 21-year-old housewife, was first seen by me on July 23, 1941, because of a sudden moderately severe hemoptysis. She had a letter from her attending physician in Iowa stating that she was subject to these hemorrhages, and that a tentative diagnosis had been made by the State University of Iowa, of a possible aneurysm of the right pulmonary artery with a patent ductus arteriosus.

Past History.—Her past history was obtained from the records of the State University of Iowa: When she was six years old, she was told that she had some form of heart disease. She was seen in the cardiac clinic and was told that she had a leakage of the heart. When she was eight years old she remembered that all her joints were hurting and swollen. She does not remember how long, but knows it lasted at least three weeks. All her joints were involved and she could not stand to have blankets on her limbs. She had always played hard with other children. She had been slightly short of breath in the last few years, but, while one flight of stairs did not bring this on, two would. She had a crowding and dull pain around her heart, and this would also occur occasionally when she would lie down. The patient stated that she had pneumonia in June and September of 1937. The second attack was accompanied with fever, chills, cough and hemoptysis. She was in bed for four weeks the first time. She did not regain her strength after the first attack, and felt feverish and chilly between the two spells of pneumonia.

Since these spells of pneumonia she has had repeated spells of hemoptysis, chills, and fever, pain in the right

base anteriorly, with loss of weight and appetite (140 pounds last year, 122 at present. Maximum weight, 140 pounds). The blood in the sputum varied from a speck to 1 or 2 ounces, and it was usually dark. She might have this 2 or 3 times a week, and then none for 2 or 3 months. She was in Sunnyslope Sanatorium for ten months in 1937 and 1938, and the final diagnosis was negative for tubuerculosis, negative sputum, "spot on right lung." She has had chest plates regularly, the last one being last summer, 1940, and they showed a healed spot. In the last year she has noticed increasing fatigue. The patient stated that her mother had often said that she was a blue baby.

Physical examination in November, 1940, revealed a well-developed, well-nourished, white female who did not appear to be ill. The skin was negative. There was no cyanosis. There was no clubbing of the fingernails and there was no edema. The head was negative. There were bilateral tonsillar tags. The teeth were in good repair. The left shoulder was carried somewhat lower than the right. There was no lag of expansion, and no change in the vibratory phenomena. The breath sounds were unchanged. There were no râles, rubs, or ronchi. The percussion note was normal. There was no cardiac enlargement. There was a long thrill palpable over the base of the heart. There was a long diminuendo murmur, starting just before the first sound and ending in diastole heard best at the left second and third interspace near the sternum, and transmitted down to the left toward the apex. The blood pressure was 125/70. The pulse was 80 and regular. There was a capillary pulse present in the fingernail beds. The abdomen was scaphoid, and there were no masses, tenderness, spasm, or herniae. The aorta was readily accessible. Pelvic examination was negative. Neurological examination was negative. Urine examinations were negative. The Hb was 14 grams, RBC 5.0 million, and WBC was 10,000, with a normal differential. The tuberculin test was negative. An electrocardiogram was negative.

bases. Acid-fast smears were negative. A guinea pig was inoculated and found negative. The patient was bronchoscoped. There was a smooth, rounded swelling which appeared to be present in the region of the lower right middle lobe above the septum. No biopsy was done. The blood Wassermann was negative. The material from the bronchoscopic aspiration revealed no growths when cultured.

Impression.—Congenital heart disease, probably patent ductus arteriosis, and probably benign tumor of the lung.

The patient was seen in the Medical Clinic, March 12, 1941. Since her discharge from the hospital in December, 1940, she has felt well and has been working. She has had two hemoptyses, but no other symptoms. Physical examination disclosed no change from the findings of her hospital admission previously. X-ray of the chest also showed no appreciable change in the shadow. The x-ray department now felt that the shadow in the right lung field was most probably an aneurysm of the right pulmonary artery; and since she is also thought to have a patent ductus arteriosus, it is reasonable to assume that the aneurysm is also congenital.

Physical Examination.—Physical examination (July, 1941), revealed a pale, well-developed and well-nourished white female, lying on the bed with her head over the side and blood streaming from her nostrils and mouth. After the hemorrhage subsided, her pulse was 120 and blood pressure 118/80. The heart was not enlarged. No thrill was palpable; but there was a loud, long continuous, systolic murmur, heard best at the second left intercostal space near the sternum. There was dullness to percussion over the right base posteriorly with numerous coarse-to-fine râles. A blood count made several days later showed: Hb 55 per cent, RBC 2,620,000 and WBC 10,000, with a normal differential. The urine was normal and the electrocardiogram was negative. The chest cleared up and her blood was restored to normal with the conventional methods of treatment. She was relatively symptom-free, except for an occasional hemoptysis. Then

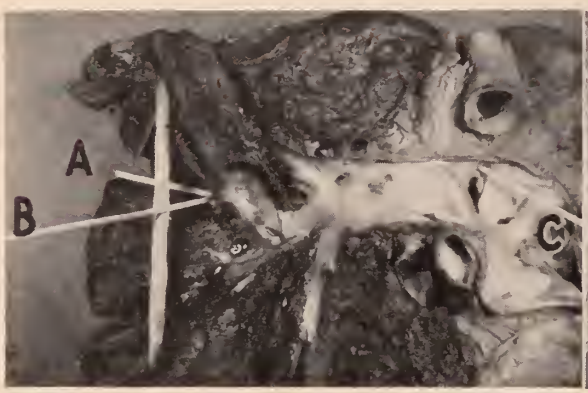


Fig. 1.—*Anterior View:* A, aneurysmal sac; B, opening into bronchus; C, patent ductus arteriosus.

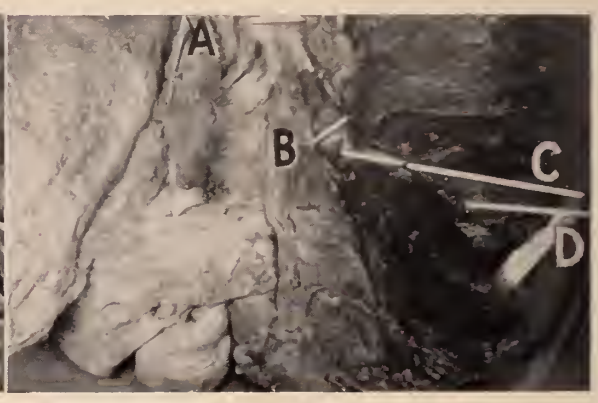


Fig. 2.—*Posterior View:* A, bifurcation trachea; B, right bronchus; C, communication between aneurysm and branch of right bronchus; D, aneurysmal sac; the darkened middle lobe is filled with blood.

A chest plate showed a bronchosinusitis chest. In the right base there was a shadow of increased density, sharply bordered, measuring 3 cm. in diameter. A lateral view showed this to be located in the midportion of the lung immediately in front of the spine. It was the impression of the Department of Roentgenology that this represented a benign tumor of the lung. The contour of the heart was somewhat suggestive of rheumatic heart disease. A left lateral esophagram showed no evidence of left auricular enlargement. Lung mapping was done, and showed a very mild cylindrical bronchiectasis in both

she had another hemoptysis on November 21, 1941, which was a little more severe, and from then to her fatal hemorrhage on June 1, 1942, she had felt better than ever before.

During the time while under my care her complaints were: cough, productive-fresh and dark blood from time to time; dyspnea only on exertion; sense of fullness in the right chest, especially when lying down, and occasionally a dull pain around her heart. Between her attacks of hemoptysis she felt very well.

Autopsy.—Both pleural cavities were almost obliterated by dense fibrous adhesions. The heart and lungs were removed en toto. The pericardial sac contained about 40 cc. of clear yellow fluid. The heart was pale, not enlarged, the right ventricular wall measuring 7 mm and the left 20 mm. The tricuspid, pulmonary, bicuspid and aortic valves showed no changes. The aorta was normal and the ductus arteriosus was patent. The pulmonary artery was 8 cm. in its main portion, 4 cm. on the right, and 3 cm. on the left, and 7.5 cm. from its bifurcation on the right side there was a saccular enlargement 3 x 4 cm. The sac was empty, the wall was smooth and in the right upper quadrant of the sac the wall was thin, wrinkled, with a valve-like structure which interposed between the aneurysm and the branch of the right bronchus. The aneurysm opened into a smooth, lined saccular cavity measuring 1.5 cm. in diameter. This cavity opened into a branch of the right bronchus 5.5 cm. below the bifurcation of the trachea. The left lung, and the upper and lower lobes of the right lung were pale. The middle lobe was filled with fresh blood.

COMMENT AND SUMMARY

A congenital aneurysm confined to the right branch of the pulmonary artery, with rupture into the bronchus and a patent ductus arteriosus, is reported. An antemortem diagnosis, which I confirmed by autopsy, was made by the x-ray department of the State University of Iowa. This case report makes a total of 31 cases diagnosed antemortem, and a total of 144 cases reported to the present time. The patient had relatively few symptoms and signs. There was no elevation of blood pressure, no prominence of the left side of the chest, no right-sided cardiac hypertrophy and no electrocardiographic changes. The roentgen ray was unquestionably of chief assistance in establishing the diagnosis. The occurrence of these aneurysms is rare, but it is important to emphasize their consideration in the differential diagnosis of hemoptysis.*

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* Author wishes to express his appreciation to Doctors R. H. Lage, Frank Russell and Ben Walker for their help with this report.

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NASAL ALLERGY: THE OTOLARYNGOLOGISTS' PROBLEM

IN RELATION TO SOUTHERN CALIFORNIA DISTRICTS

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THE otolaryngologists' nasal problem in Southern California, and in other similar climatic areas in the United States, is unique. In addition to the usual naso-sinusal problems, we have to contend with an unremitting nasal affliction which results in symptoms throughout the entire respiratory system, and affects at least fifty per cent of the patients referred to the otolaryngologist with chronic "catarrhal" ear, nose, and throat complaints. These patients have been diagnosed as suffering from "constant colds," "catarrh," "chronic sinusitis," "chronic streptococcic sore throat," or "bronchitis." In reality, the fundamental etiology, in most of these cases, is the perennial allergy characteristic of Southern California. The basic allergy in the majority of these cases is pollen sensitivity. It is not within the scope of this paper to consider the otolaryngological aspects of food, house dust, epidermal or fungous sensitivities.

Adequately treated naso-sinusal disease of bacterial origin usually can be cleared up readily. When the history, clinical picture, and the subsequent course is more or less befogged, and the "sinus" infection occurs again and again, the "cold" continues despite competent treatment, the Eustachian tubes block intermittently, the sore throat recurs without new bacterial infection, or the cough persists, an unrecognized hidden allergy must be predicated.

OBSERVATION IN SOUTHERN CALIFORNIA: SYMPTOMS

A minimum of fifty per cent of the patients in Southern California with perennial "catarrhal" complaints attributable to the nose and

sinuses do not give clear-cut histories. Their main complaint is nasal obstruction, which may be partial or complete, bilateral or unilateral. Usually the obstruction is unilateral, with a shift from side to side about every four hours. Cough is also a common symptom. The cough may be nocturnal and accompanied by champing and grinding of the teeth and snoring. There is almost always a morning cough, with the production of clear tenacious mucous and the freeing from the throat of a lump of mucous, mucopus, or inspissated "dark-brown" crusts. A dry sore throat is usually present, which disappears as the morning progresses. Sneezing, when present, is also an early morning feature. There may be some sero-mucoid secretion blown from the nose during the day, but the amount is larger on first arising. The patient sometimes complains of a pressure type of headache across the bridge of the nose, and extending over the cheeks, and with a sense of fullness behind the eye. The headache may also involve the frontal area, especially over the glabella. Very often the individual will mention that he feels mentally dull, is unable to comprehend conversation or written text readily, and that his eyes tire easily. These symptoms of headache, pressure, and mental clouding, as well as the complaints mentioned before, are usually relieved when adequate nasal ventilation is established by topical or internal administration of sympathomimetic drugs.

The affliction, caused by the perennial Southern California pollens, is constant throughout the year. It is infrequent that the patient will give a history showing regular seasonal exacerbations. When intermittent flare-ups of the habitual symptoms do occur, the patient will declare that he "caught a cold" at those particular times, and usually will not associate the increase in symptoms with his inveterate grievances. The more or less mild, perpetual naso-sinusal-pharyngeal-bronchial effects continue day-in and day-out, without reference to weather or to occupation.

PHYSICAL APPEARANCES

Examination of these cases will sometimes show the classic bluish-white congestion of an allergic mucosal lesion. The oedema may be bilateral involving the septal, middle turbinal, and especially the inferior turbinal mucosa. Usually only one side is affected at the time examined, and later the nasal mucosa in the other airway will be swollen. A more advanced stage is occasionally found in which the nasal mucosa has become more pearly, the involvement is bilaterial, and the swelling recedes very little, except with the very strongest of con-

CHART I POLLEN SEASONS

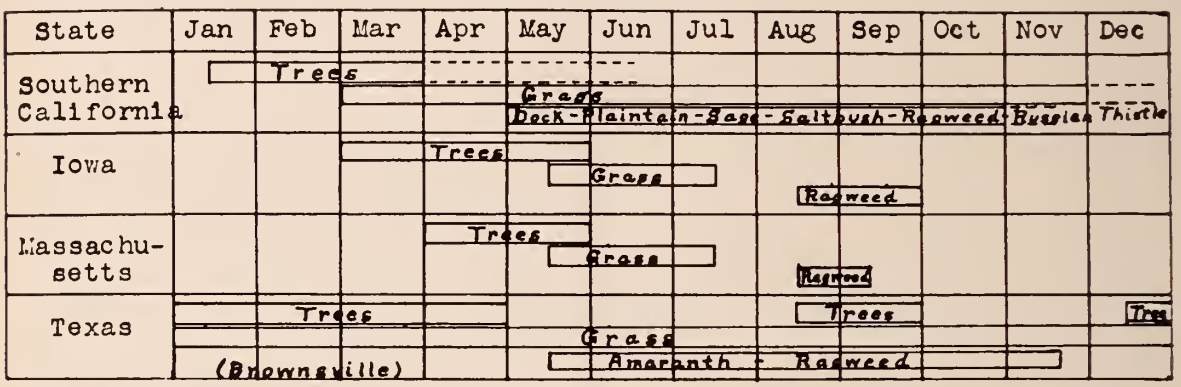
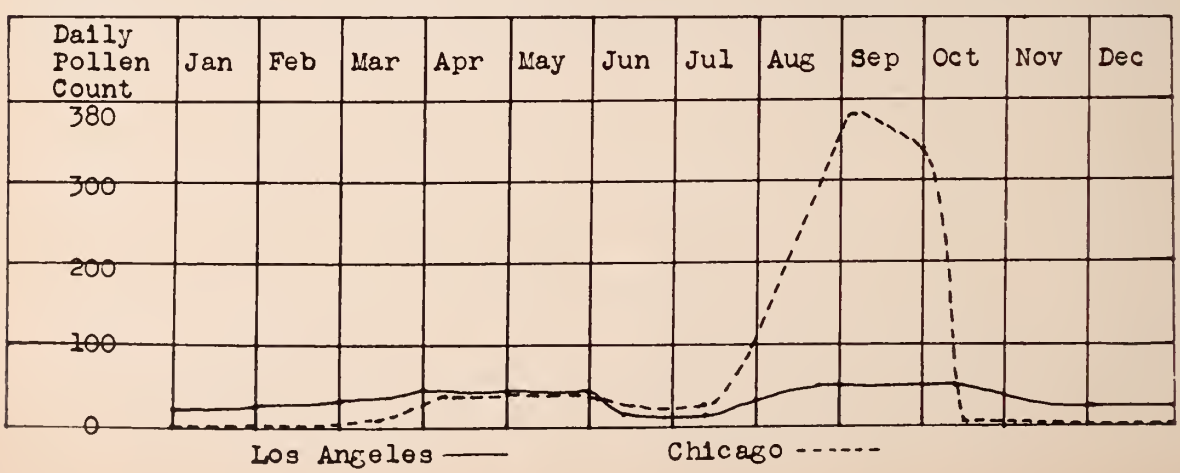


CHART II DAILY COMPARATIVE SLIDE COUNTS OF POLLENS - 1940



stricting drugs. The pharyngeal wall commonly will show lateral bands and a studding of lymphoid follicles on the posterior surface against a pale mucosa, which extends downward to the hypo-pharynx.

OTHER EXAMINATIONS

Transillumination, in the absence of secondary or prior sinusitis, is clear and equal, and of little value except in searching for secondary infection.

X-ray examination will usually show a uniform thickening of the sinus mucosa, especially in the antra and ethmoids. The lungs will show a thickening of the bronchial-tree shadows.

Smear examination of the nasal secretions rarely shows a sufficient number of eosinophiles to be of definite value. If a positive eosinophilia is demonstrated, it may be taken as confirmation of the indicated allergy. However, a negative smear, or even repeated negative smears, does not annul the allergic diagnosis. Secondary infection, although slight, will invalidate the eosinophile test.

DIAGNOSIS

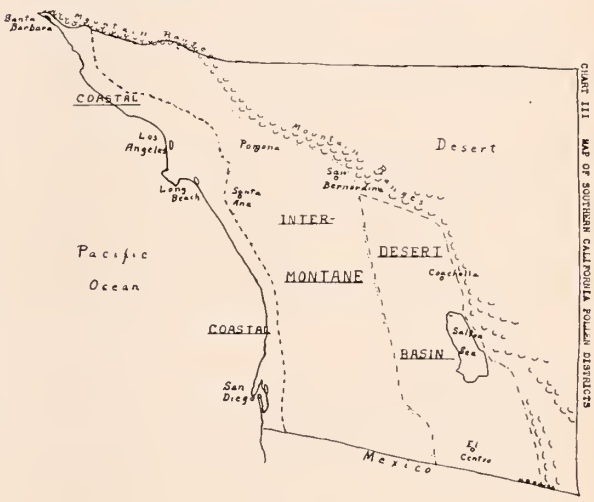
In Southern California, and similar climatic areas in the United States, allergy of the respiratory tract may simulate most of the signs and symptoms of acute or chronic infection of the nose, sinuses, pharynges, or bronchi. The diagnosis of the allergic etiology is not recognized because the indications commonly attributed to hay fever or asthma are not present. Perennial pollen allergy may produce chronic nasal obstruction without sneezing, and without any appreciable mechanical or adenoid factor. Allergy alone may produce recurrent rhinorrhea and nasal obstruction without infection being present, except as a secondary invader. Pollen allergy may produce persistent or recurrent sore throats without pharyngitis or tonsillitis, and intermittent Eustachian tubal blockage without infection. Allergy alone may produce a chronic or intermittent cough without infection of the bronchi, and without wheezing or dyspnoea. Allergy alone may produce recurrent bronchopneumonia with fever, leukocytosis and tachypnea, without wheezing and without pneumococci.

The chronic allergic congestion prevents adequate aeration and drainage of the nasal sinuses. Hence, an upper respiratory infection may develop into a stubborn secondary sinusitis. Mechanical nasal obstruction, due to septal or turbinal irregularities, will be accentuated by the allergic oedema. It is necessary, therefore, in order to relieve this type of chronic nasal victim of his symptoms, to prevent recurrences, and to disprove the laity accusation of "once a sinus, always a sinus," that not only must the allergy be investigated and brought under control, but also any infectious or mechanical naso-sinusal disabilities be remedied. We feel that this is the job of the Otolaryngologist. He is in position to follow the patient closely, his training and experience shows him pathological changes earlier, and he is able to correlate naso-sinusal and allergic treatments which give more rapid and more permanent relief of symptoms.

SOUTHERN CALIFORNIA ENVIRONMENT

The Otolaryngologists' nasal allergy problem in Southern California is difficult because the pollen irritation is perennial. In this semi-tropical climate foods may cause year-around nasal symptoms and "catarrh," but more commonly it is the flora. In this respect we are not fortunate enough to have distinct seasonal variations which give sharply demarcated pollination. Alabama, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, and Texas have the same problem to a similar or less degree as Southern California. Texas is the only state that apparently outdoes Southern California in this respect. For example, among trees, the acacia, pepper, cypress, and eucalyptus bloom all year 'round. Bermuda grass blooms perennially, and many other grasses and plants pollinate in and out of season all year; especially Franserias (Ragweed), Artemesia (Sagebrush), Atriplex (Saltbush), Amaranth and Chenopods.

CHART 3.—*Map of Southern California Districts*



There are two other factors which add to the constant pollinosis. No matter what their season, plants will spring up and flower any time of year if irrigating water or any other source of moisture comes into contact with them. Secondly, although most of the pollens are shed in the Spring, Summer and Fall, the dryness preserves the pollens and they are blown about all year long, often in great numbers and for long distances.

DISTRICTS WITHIN SOUTHERN CALIFORNIA

The allergy problem in Southern California is made more complicated by the fact that within its boundaries there are three varying geographic

areas, with blending but characteristic pollen allergy differences. "Southern California," itself, may be described, polliniferously, as beginning in the north at the Amigdio mountains, which are an east-west spur of the Coastal Range just north of Santa Barbara. The boundary then runs east and south along the Coast Range, and east through the San Gabriel and San Bernardino Mountains, to end in the Sierra Nevada Range which forms the Eastern border of the territory to be considered. The western limit, beginning at Santa Barbara, is the Pacific Ocean. On the South is Mexico.

The three incorporated districts of Southern California will be designated as the Coastal, Intermontane, and Desert Basin areas. These regions have differing floral and meteorological characteristics, and, hence, different pollen allergic problems. The allergic patients will give diverse histories and dissimilar test reactions, although they usually respond equally well to therapeutic injections. The variations of each area blend into the others.

The *Coastal Area* is essentially a ten-mile strip extending immediately along the Pacific Ocean from Santa Barbara and the Amigdio Mountains to San Diego and the Mexican border, with a bulge eastward at the Los Angeles basin region to include metropolitan Los Angeles and the adjacent locality.

The *Intermontane District* emerges from the

TABLE 1.—*Comparative Chart of the Major Features of the Three Southern California Pollen Areas*

Coastal Area	*Intermontane District*	*Desert Basin*
	History	
1) Perennial symptoms.	1) Perennial symptoms with rare seasonal exacerbations.	1) Seasonal symptoms with the perennial case infrequent.
2) Symptoms tend to involve the entire upper respiratory tract, but with the naso-sinusal area most effected.	2) Symptoms tend to affect the naso-sinusal area most frequently, but spread rapidly to the rest of the upper respiratory tract with exacerbations.	2) Symptoms tend to be more localized and do not extend readily.
3) Patients from outside Southern California who continue seasonal allergy develop perennial symptoms in about three years.	3) Patients with seasonal allergy develop perennial symptoms in about three to four years, but have seasonal exacerbations for several years longer.	3) Seasonal type of allergy persists, but usually at different times of the year than previously.
4) Symptoms often precipitated by fog.	4) Symptoms may be precipitated either by fogs or by winds, especially from the desert.	4) Symptoms precipitated by winds.
5) Symptoms not relieved at the sea-shore.	5) Symptoms generally relieved at the sea-shore.	5) Symptoms relieved at the sea-shore.
Coastal Area	*Intermontane District*	*Desert Basin*
	Diagnosis	
1) Examination of the nasal mucosa may be indicative, but not typical of allergic reaction.	1) Examination is usually indicative of an allergic mucosa, but is rarely entirely typical.	1) Examination usually shows typical allergic mucosa.
2) Nasal smear for eosinophilia is usually valueless.	2) Nasal smear for eosinophilia is usually valueless, but occasionally will be positive.	2) Nasal smear for eosinophilia is usually positive.
3) Scratch test reactions produce erythema, with wheal formation small and infrequent. Erythema diagnostic.	3) Scratch test reactions usually give small wheals and moderate erythema. Wheal formation diagnostic and erythema indicative.	3) Scratch test reactions produce large diagnostic wheals.
4) Intradermal tests usually necessary and usually conclusive.	4) Intradermal tests may be necessary and are usually conclusive.	4) Intradermal tests are not necessary and may be dangerous.
5) Eighty per cent of the patlents tested will show indicative reactions to scratch and intradermal tests.	5) Ninety per cent of the patients tested will show indicative reactions. Scratch testing will be sufficient in 80 per cent, and Intradermal testing will give results in another 10 per cent.	5) Ninety-five per cent of the patlents tested will give indicative reactions to scratch testing. Intradermal tests may be used only with the greatest caution.
	Treatment	
1) Best results by correlating otolaryngological and allergic treatments.	1) Best results by correlating otolaryngological and allergic treatments.	1) Best results by correlating otolaryngological and allergic treatments.
2) Injection treatment with the Indicated allergic antigen, especially by the perennial method, gives excellent or very good results in 80 per cent of the patients.	2) Injection treatment with the indicated allergic antigen, especially by the perennial method, gives excellent or very good results in 90 per cent of the patients.	2) Injection treatment with the Indicated allergic antigen will give good results In 80 per cent of the patients.
3) Nonreactors and poor reactors to the tests comprise about 20 per cent of the patients. Fifty per cent of these cases will respond to empirical allergy therapy — the antigen being made from the pollens In the air at the tlme of the most severe symptoms.	3) Nonreactors and poor reactors to the tests comprise about 10 per cent of the patlents. Twenty-five per cent of these cases will respond well to empirical allergy therapy.	3) Nonreactors and poor reactors to the tests comprise about 10 per cent of the patients. Results are poor to any type of treatment.
		4) Results with the perennial type of patient (less than 10 per cent of the cases), with any type of allergy treatment, are only falr.

Coastal area and includes principally the San Fernando Valley, which lies north and west of Los Angeles, and spreading eastward and southward into the valleys surrounding Pasadena, Monrovia, Pomona, and Santa Ana, then fading into the Desert Basin to the East and South.

The *Desert Basin* comprises the low-lying irrigated Coachella and Imperial Valleys and their extensions.

The major variations between these three Southern California areas in regard to history, diagnosis, and treatment can be shown easiest by means of the following comparative chart. Naturally, there is a gradual transition from one region to the next, so that varying combinations may occur along each of the designated boundaries.

COMMENT

The continual exposure of susceptible individuals to pollen antigens develops a low-grade resistance which is not sufficient to prevent the allergic lesions, but which results in minimum reactions to testing. The large wheal formation, which is considered essential for a positive reaction in other parts of the United States, is found most often in the Desert Basin area of Southern California. Small wheal formation is usually produced in the Intermontane district and erythema in the Coastal region. However, the erythema and small wheal formations of these two areas are as diagnostic as the large wheals seen in other localities in the United States.

The unremitting pollinosis gradually transforms seasonal types of allergy into perennial forms within three to four years in the Coastal and Intermontane regions, if adequate treatment is not instituted.

Between 80 and 95 per cent of the patients, who have been diagnosed clinically as having a primary allergy, will show sufficiently indicative reactions, so that the offending pollens can be incorporated into a specific treatment antigen. The other individuals who have produced equivocal or no reactions to the testing usually will provide a hint in the carefully-taken history, so that certain pollen combinations may be selected and given empirically with gratifying results.

In the Desert Basin it is necessary to use high concentrations of the two or three more active pollens in order to obtain results. In the Coastal and Intermontane areas a considerable number of the offending pollens, in moderate concentration, may be incorporated into one treatment antigen. The danger of anaphylaxis is ever present in the Desert Basin, but, due to the acquired low-grade resistance of the Coastal or Intermontane patient, it is less serious a factor in these areas. Oriental patients, however, must always be treated with the greatest of care.

CONCLUSIONS

1. Recurring "sinusitis," "bronchitis," "constant colds," and "catarrh" are terms often used because of ignorance of the true etiology.

2. These upper respiratory tract lesions, especially in Southern California, usually are due to an unrecognized or hidden pollen allergy. This allergy may cause a secondary sinusitis or other infection of the upper respiratory tract due to blockage, in the presence of a coincidental bacterial invasion.

3. Any upper respiratory infection which tends to recur, or is stubborn in improving, probably has an allergic background; ruling out, of course, structural abnormalities and secondary infections.

4. The basic pollen allergy problem in Southern California, and similar climatic areas such as Alabama, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, and Texas, is unusual and very difficult, due to the perennial pollens in the air.

5. Southern California contains three pollniferously differing districts which produce varying histories, clinical findings, and reactions to allergic testing.

6. The continuous exposure to pollens builds up a low-grade resistance, which tends to produce minimum results to allergic tests without being of benefit to the patient. This unremitting pollen absorption causes seasonal types of allergy to become perennial in about three to four years, if adequate treatment is not instituted, in the Coastal and Intermontane regions.

7. The Otolaryngologist is in the most advantageous position to correlate the necessary nasosinusal and allergic treatments in order to obtain the most rapid and permanent relief of the symptoms.

8. Perennial pollen treatment, including empirical treatment with the indicated pollens in cases where the tests have been inconclusive, have been of great benefit in these so-called "uncurable" cases of recurrent "sinusitis," "constant colds," "catarrh," and "bronchitis."

281 South Thomas Street.

CHEMICAL INJURIES OF THE EYE: THEIR TREATMENT

WITH SPECIAL REFERENCE TO WAR GASES

HAROLD F. WHALMAN, M. D.*
Los Angeles

CHEMICAL injuries to the eyes occur as a result of splash, spray, or gaseous contact with exposed parts such as skin, conjunctiva, or cornea tissue primarily. The irritation set up and secondary infection may lead to involvement of deeper structures such as the sclera, the anterior or posterior uveal tract, continuing on to panophthalmitis and phthisis bulbi.

SYMPTOMS AND SIGNS

Subjective Symptoms. — Lacrimation, photophobia, stinging pain, and blurring of vision are

* Clinical Professor of Opthalmology, College of Medical Evangelists, Los Angeles.

followed by aggravation of the symptoms with anxiety and apprehension which must be allayed by adequate sedation and reasonable assurance, as well as the indicated local treatment, all depending on the chemical agent and the extent of the injury.

Objective Findings.—The skin and conjunctiva show first, second, or third degree involvement with hyperemia, tearing, steaminess of cornea or possibly eschar. Marked swelling of lids and conjunctiva ensues and ulcerative keratitis may follow.

Sequellae.—If the skin suffers third degree burn the resulting eschar produces an eversion of the lid or cicatricial ectropion. If the conjunctiva suffers similarly symblepharon or entropion results from the contraction of the scar; the eyelashes are turned against the eyeball producing intolerable irritation and at times secondary ulcerative keratitis.

Should the cornea be directly attacked opacification results in proportion to the depth of penetration of the chemical agent. Nebulae, maculae, and dense leucoma are the sequellae, the latter sometimes breaking down with frequent recurrences. Calcium deposition is common.

ALKALIS

Of the alkali burns the most frequently encountered agent is lime which often causes deep penetrating trauma on account of its tendency to continue its activity. Contact should be promptly followed by profuse and thorough lavage of all particles from the cornea and conjunctival sac with boric acid, saline or water whichever is most readily available. Particles which tend to stick may be dislodged with applicator or forceps. The cornea should be anesthetized with one-half per cent pontocain and an eye bath of ten per cent neutral ammonium tartrate used, this process to be repeated every two to three hours for several days. Neutral ammonium tartrate dissolves the calcium carbonate which forms in the tissues from lime. After this fresh castor oil may be instilled and dark glasses worn. Do not cover the eye with any dressing from which the escape of tears may be impeded; cold boric compresses, frequently changed may be used however. One-half per cent pontocain is used to quiet sensory pain and one per cent atropin to abate pain of ciliary spasm.

Severe blepharospasm may be controlled by injections of the terminal branches of the seventh nerve with novocain to facilitate treatment.

ACIDS

In contradistinction from alkalis, acids act quickly, fix quickly and do not continue penetration. The eye should be promptly flushed with one to two per cent sodium bicarbonate, saline, or plain water. Then pontocain, atropin, castor oil, compresses, and dark glasses may be utilized, but again—do not bandage.

SOLVENTS

Ether and ethyl chloride do no harm whereas alcohol of over fifty per cent concentration will destroy the epithelium of the cornea. Regeneration takes place, however, in one to two days usually without impairment of vision.

Acetone also destroys the epithelium and may set up a keratitis resulting in corneal opacity. Carbon tetrachloride used in cleaning fabrics and carbon bisulfide used in the rubber industry act similarly to acetone.

WAR GASES

Tear Gas.—Tear gas (chloracetophenone) is as the name implies a lacrimator and is intended to disable by producing discomfort and belpharospasm, but if the contact is liquid rather than gaseous it may set up an irritative keratitis, subsequent fibrosis, corneal opacity and its consequent loss of vision.

Treatment comprises voluminous flushing with boric, saline, or water, as available. Four-tenths per cent (0.4 per cent) sodium sulfite in seventy-five per cent glycerin and twenty-five per cent water is a specific however, and should be instilled every hour for one to two days, using one-half per cent pontocain as a preliminary anesthetic. Use castor oil, dark glasses, compresses, but no bandage.

The skin is treated by wiping with cotton balls soaked in a solution of four per cent sodium sulfite in fifty per cent alcohol.

Mustard Gas.—This gas chemically known as dichlorethylene sulfide is soluble in the oil of the skin, and combines with water to produce hydrochloric acid in the tissues. It produces an immediate irritation which has a mild appearance at first, but soon its penetrating effect produces desquamation of the corneal epithelium, conjunctival edema, and sometimes corneal destruction, iritis, and even panophthalmitis.

The best lavage is sodium bicarbonate one to two per cent which neutralizes the hydrochloric acid. Since dichlorethylene sulfide is soluble in oil, castor oil should not be used. Bandages should not be used. Late swelling and pain is usually severe so adequate sedation will be required. Recurrent ulcerative keratitis may persist for years.

Lewisite.—All that has been said about mustard gas applies to this gas.

Phosgene.—The writer knows of no adequate neutralizing agent for phosgene and its treatment comprises lavage, local and systemic sedatives, no castor oil, no bandages. Its destructive action is similar to mustard gas and Lewisite.

727 West Seventh Street.

The Art of Medicine is largely the art of noticing.—*J. A. Ryle.*

We American writers have one of the great stories of the world to tell, if we have the wit to tell it truly. There is no surer way that I know, of fitting ourselves for the future, than by gaining an understanding of what the ordinary citizen, who has to work for his living, has been doing and thinking and hoping through the course of formal history.—Walter D. Edmonds.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICE

72ND ANNUAL SESSION CALIFORNIA MEDICAL ASSOCIATION, LOS ANGELES, MAY 2-3, 1943

Re: Reports of Meetings

The May issue of CALIFORNIA AND WESTERN MEDICINE is in press at the time when the California Medical Association convenes to hold the 72nd annual session.

Full reports of the proceedings will appear in the June number of CALIFORNIA AND WESTERN MEDICINE. It is possible, however, to make the statement that the general opinion of the session was most favorable, general and section meetings being well attended and of value. The military exhibits and films were likewise of interest.

The attendance was good as evidenced by the following registration figures:

Total C.M.A. Registration at Los Angeles was 1184.

Total Woman's Auxiliary registration was 174.

The "Dinner to the President" was attended by 933 physicians and families, every seat in the Biltmore Bowl being taken in advance, with more than one hundred seeking places that were not available.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

WAR MANPOWER COMMISSION

Editor's Note.—The four statements which follow are referred to in a letter dated May 6, 1943 and signed by Frank H. Lahey, M. D., Chairman of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. For copy of Dr. Lahey's letter and editorial comment, see in this issue on page 263.

The enclosures referred to in Dr. Lahey's letter appear here in the following sequence:

I. Statement of the Surgeon General of the United States Army.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Francisco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U.S.N. The Senior Medical Officer is Captain John C. Ruddock, U.S.N.R. The office is located at 411 West Fifth Street, N.W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

II. Statement of the Surgeon General of the United States Navy.

III. Statement of the Surgeon General of the United States Public Health Service.

IV. Statement of the Chairman of the Directing Board of Procurement and Assignment Service for Physicians, Dentists and Veterinarians.

I

Statement of the Surgeon General of the United States Army

The Army is increasing in size; more medical officers are required. New units are being formed and many new general hospitals are under construction at many points in the United States. Some basic training must be given to medical officers before they are assigned to purely medico-military duties; for this reason, they are needed one or two months prior to actual assignment. For the protection of the health of the civilian population, the quotas for physicians must be fairly distributed throughout the country. Certain states are far behind; they will, it is hoped, do everything possible to furnish their quotas at once.

II

Statement of the Surgeon General of the United States Navy

In order to plan intelligently I have reviewed the personnel situation in the Medical Department of the Navy. There is a deficit of approximately nine hundred medical officers for the next six months, based on minimal requirements. The Bureau of Medicine and Surgery calls medical officers to active duty when billets are available, does not build up too large a Reserve at any time. Consequently, procurement must go on in an orderly fashion, if we are to meet the demands that will be placed upon us as the offensive fighting develops. We cannot afford to have the deficit increase beyond its present level; if it does we will not be able to give first-class medical service to our wounded.

The Medical Department of the Navy is charged with maintaining the health of all the personnel of the Navy and the Marine Corps; in addition it must care for the dependents of the officers and men. We look to the medical profession of our nation to come forward with the available doctors that can be spared from civil life to aid in our military necessity. In the main, the profession has responded nobly. There are some localities where this is not so. In those localities the medical profession should cause the pressure of public opinion to bear on all eligible doctors and thereby bring to their attention the seriousness of failing to do their patriotic duty.

The medical profession is faced with a challenge of furnishing medical service to the Armed Forces and to the civil population during the active state of war and in the post war period, which we hope is not too far distant. Should the profession fail in either regard many forces may develop that will destroy the practice of medicine as we know it. This would be disastrous and it is something that we cannot afford to allow to come about. In all seriousness, the doctors of medicine in the United States should take stock carefully of their own immediate situations and should give every assistance in planning to see that medicine plays its responsible part in this and coming years.

III

Statement of the Surgeon General of the United States Public Health Service

During the next twelve months, the Public Health Service will require approximately 600 medical officers for full-time active duty in the reserve commissioned corps. These physicians will be recruited on an average of 50 a month—25 for service in the U. S. Coast Guard, and 25 for general service.

In addition to the medical officers assigned to the Coast Guard, physicians are needed for duty in the Marine Hospitals and the medical program of the War Shipping Administration, as well as for detail to general public health work in State and local health departments, and for such specialized war programs of the Public Health Service as tuberculosis control, venereal disease control, industrial hygiene, and community medical services.

The Service also expects this year to commission some 5,000 physicians in the inactive reserve. These doctors will be available for active duty in the event of acute emergency in their own or nearby communities. They will not be called for active duty unless an acute emergency exists, and will be retained only for the duration of such an emergency. This recruitment of inactive officers is undertaken as a part of the coöperative program of the Public Health Service and the Office of Civilian Defense.

The needs of State and local health departments for physicians have increased greatly during the past year. In January, 1942, it was estimated that State and local health departments would need 600 physicians. As of January, 1943, the exact needs have not been determined, but the Public Health Service has, at the present time, requests from the States for 185 medical officers to be assigned to duty in war areas alone.

According to reports from State Procurement and Assignment chairmen, as of March 23, 1943, 286 additional doctors for civilian practice are needed in 176 counties located in 38 States. Another 22 counties in the same States report a shortage of physicians but do not specify the numbers needed. In the remaining 10 States, no needs were reported.

These 198 counties reporting immediate needs represent only 7 per cent of the 2,654 counties in the 38 States, and only 6 per cent of all counties in the country. Nevertheless, it is apparent that civilian communities are feeling the pinch of the physician-shortage increasingly, since experience has shown that local needs become acute before they are expressed in formal reports. In the joint studies made in 42 areas by the Public Health Service and the Procurement and Assignment Service, it has been determined that 59 physicians and 5 dentists, or 64 medical and dental personnel, are needed in these areas —an average of 1.5 per study. The Public Health Service has been requested to supply 13 of these physicians and dentists, or 23 per cent of the determined need.

On the basis of these 42 studies, it is estimated that 500 physicians and dentists will be needed in 332 areas to be surveyed in the next coming fourteen months, or by June 1, 1944. It is anticipated that 80 per cent of these, or 400, will be supplied by voluntary relocation through the regular channels of Procurement and Assignment, and that the Public Health Service will be requested to assist in meeting the needs for the remaining 20 per cent, or 100 physicians and dentists. This may be done either through financial assistance to physicians desiring to relocate in areas requiring their services, or through assignment of Public Health Service personnel upon request of the proper authorities.

Although it is impossible to project with accuracy the 1943 needs of civilian communities, we must face the fact that the shortage undoubtedly will increase during and after the filling of the 1943 military quotas; and that the chances of meeting civilian needs as well as replacing physicians who die or withdraw from practice be-

cause of disability, will correspondingly decrease. Furthermore, we cannot predict at this time the possible needs of certain rural areas, which now may be adequately supplied but which will require additional public health and medical services during 1943, should the Government move a large number of farm families into these areas for the food production drive. It is believed that joint action of the Public Health Service and the Procurement and Assignment Service will serve to meet urgent needs in civilian communities.

IV

Statement of the Chairman of the Directing Board Procurement and Assignment Service for Physicians, Dentists and Veterinarians

Figures are now complete on the 1942 quotas for supplying physicians of the various States. Forty States have exceeded the 100 per cent figure of their quotas. Five States were above 90 per cent of their quotas. Four States—New York, Connecticut, Massachusetts, and Nevada were below 90 per cent of their quotas.

Nevada is the lowest State, but has a total quota of but 35 doctors. It has provided 23 and deserves special consideration because its population is thinly scattered over wide areas.

This statement would not imply any reflection on the patriotism of those members of the medical profession who have been marked available by the Procurement and Assignment Service in these three States and who have not sought a commission. I would only present the facts and let each one draw from these facts whatever deductions he individually chooses.

Certain unavoidable considerations must be faced in these figures. Four States failed to provide 90 per cent of their 1942 quotas of doctors for the services. Three of these States—New York, Connecticut, and Massachusetts, are Eastern Seaboard States and among the most populous ones in the Union. These populous States have large cities in them which now have more doctors per thousand persons than most other parts of the country. Largely because those doctors marked available by the Procurement and Assignment Service have not sought commissions, these States are below their quotas.

Unless more of the doctors found available for military service by the Procurement and Assignment Service in these cities apply for a commission in the armed forces with reasonable promptness still more doctors must come from rural communities. This will greatly complicate the problem for those communities in their own and other States since many rural communities are already none too well supplied with doctors. Such inequalities in medical service as now exist are practically insurmountable for the Procurement and Assignment Service with its present limited authority. With all these facts in mind, with the responsibility of medicine to the country and to itself such as it is, *the quota figures* particularly in New York, Connecticut, and Massachusetts *should be brought up to par by an intensive effort of the State Medical societies through their executive bodies preferably by an organized State Medical society campaign.*

The provision of doctors for the armed forces is not only the special obligation of medicine but a responsibility which it acknowledges and accepts as its part in the war effort. Each State that has not met its 1942 quota will be kept informed of its position in relation to its quota and its position in relation to other States. Otherwise, a State is denied the pardonable pride of satisfaction in meeting its quota or pampered against facing a distasteful position in relation to other States.

PRO PATRIA

Note. The Editor will be pleased to receive letters from C.M.A. members, who in turn have heard from colleagues in military service. (The original letters will be returned after "copy" has been set in print.)

Members of the Association, who are in service with the Armed Forces in the United States or elsewhere, are also invited to write the Editor concerning their experiences. Colleagues in civilian practice will be happy to hear from them.—Ed.

(COPY)

From Albert G. Bower, MC
U. S. Naval Hospital
Navy No. 10, C/o F.P.O.
San Francisco, Calif.

May 5, 1943.

Dear Doctor Kress:

Many thanks for your kind letter and the enclosed copy of Captain Buddy Horner's Pro Patria letter. It sounded like a roster of San Francisco's finest. However, there are a few more fine Californians working around here from other parts and counties. There is Fetter and McPherson from San Diego; Gates from Santa Barbara; Barnum, Butt, and Wright from Pasadena; Silver and Joe Stevens from Hollywood; Rosove from Santa Monica; Larson, Smedley, Harold Cummings, Roy Falconer, Von Briesen, Carter, Kaplan, from Los Angeles; Gunther from Long Beach; and not mentioned in a previous letter, Leo Stanley and Rapaport from up North. In fact, we have quite a California outfit.

The duty, here, is a tour at Shangrila. Anyone that gripes at this duty just doesn't know what a tough tour of overseas' duty can be like when the going is really hard. Of course, the gang miss their wives and families, and their home associations and work, but in so far as a tour of duty away from the mainland can be made pleasurable, this is it. After all, we're here to help win a war! This new hospital is the finest owned by any of the armed services off the mainland. Only recently completed, everything is modern and up-to-date. We are moderately busy, and with the changing tides of war, may be much more so in the future. Our colleagues, we greet you.

Aloha,

ALBERT G. BOWER,
Cdr. Albert G. Bower, MC-V (S) USNR.

(COPY)

From Otto H. Pflueger, M.C.
Air Corps, United States Army

April 5, 1943.

Dear George:

Greetings from Blythe, California. I got back to California but not to a particularly lovely part of the same. As you must know, Blythe is down here in the middle of the desert on the California-Arizona border—a hundred miles or more from nowhere. Wind, sand and heat —plenty of the last two especially and often of the first. The desert has a certain charm, however, which I like—the nights are beautiful. Of course they are only used for sleep and/or movies and reading and writing.

Miami Beach was lovely and I enjoyed it although there was plenty work. Got in good shape (physically).

I have been here just over two weeks—we have a good hospital of the type you undoubtedly know the army has

in these locations—about 150 beds. I am chief of the surgical service—have about 50 beds—another surgeon is here—we have good equipment—not a great variety but enough. We don't expect to do colon and gastric resections and we hope no accident work of any great moment, because that means planes down which we do not want.

Would you be so good to send me the last two or more issues of C. & W. M., and then monthly as long as I am here? Would like to know about the Los Angeles meeting. With my best regards, I am,

Sincerely,

OTTO.

CAPT. OTTO H. PFLUEGER, M.C.,
Station Hospital, Army Air Base, Blythe, Calif.

Medical Journals—For Colleagues in Military Service:

In former issues editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261). The "Railway Express Agency" will call for packages and will collect costs from C.M.A. The P. G. Committee will forward to camps.

Women Physicians now Eligible for Commissions in the United States Army and Navy

H. R. 1857, sponsored by Congressman Sparkman, became a law on April 17, 1943, when President Franklin D. Roosevelt attached his signature thereto.

Text of the new law follows:

(H. R. 1857, 78th Cong., 1st Sess.)

A Bill to provide for the appointment of female physicians and surgeons in the Medical Corps of the Army and Navy.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That hereafter during the present war and six months thereafter there shall be included in the Medical Departments of the Army and Navy such licensed female physicians and surgeons as the Secretary of War and the Secretary of the Navy may consider necessary, whose qualifications, duties, and assignments shall be in accordance with regulations to be prescribed by the Secretary and who shall be appointed and at his discretion removed by the Surgeon General of the Army and Navy, subject to the approval of the Secretary of War or the Secretary of the Navy. Those appointed shall be commissioned in the Army of the United States or the Naval Reserve, and shall receive the same pay and allowances and be entitled to the same rights, privileges, and benefits as members of the Officers' Reserve Corps of the Army and the Naval Reserve of the Navy with the same grade and length of service: *Provided*, That female physicians and surgeons appointed under this Act shall only be assigned to duty in hospitals or other stations where female nurses are employed.

Young Physicians Hit in A.M.A. Journal

Refusal to Enlist in Armed Services Rapped

Chicago, March 25.—(INS.)—Young available physicians who have failed or refused to volunteer as medical officers in the armed forces were severely arraigned today in an editorial in the *Journal* of the American Medical Association.

Advocating publication of their names in state medical journals, the editorial demanded:

"Let them be called before the bar of public opinion."

The *Journal* said that at a recent meeting in Washington of the directing board of the procurement and assignment service for physicians and veterinarians with the officer procurement service of the United States Army it was clearly set forth that the recruitment of medical officers was lagging.

"The responsibility," the editorial said, "rests unquestionably on the failure of the young available physicians in the large cities of the country, particularly those of the eastern seaboard, to volunteer.

"New York, Brooklyn, Boston and some of the larger communities in Connecticut, New Jersey, Pennsylvania and California have failed even to approximate their quotas."—Stockton *Record*, March 25.

U. S. Doctors: Nation Faces Medical Problem as the Military Absorbs Supply

Washington.—(AP.)—About one-third of the nation's doctors in full-time practice are now in the armed services, the Office of War Information recently said in a warning that the medical situation "as a whole is not now out of control, but unless remedial steps are taken soon it will grow progressively worse."

The OWI said that in too many cases physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population. It added:

"There are, however, enough doctors remaining in private practice to give adequate care to the civilian population, provided they can be properly distributed and according to special abilities."

The OWI said doctors now in the armed services total between 40,000 and 45,000 and as the additional physicians are called to military service, "doctors in critical areas—many of them elderly—may succumb to exhaustion from overwork."

The OWI also made these observations:

"In some communities local medical groups have resisted attempts to relocate outside doctors in their locality. In a number of instances (there was) disinclination of medical groups to allow a physician paid by the public health service to practice medicine in a particular community.

"A number of doctors questioned were against allowing refugee physicians to practice.

"The system in use at present to apportion doctors between the armed forces and the civilian population is inadequate.

"In certain cases pressure was applied to doctors who were reluctant to enter the service. A quota was set in each state for the recruiting of doctors and the states were not supposed to go beyond those quotas. In many cases they did."

Explaining the scope of its report, the OWI said:

"OWI representatives traveled through the South, the Midwest, the West, the Eastern seaboard—in three distinct types of communities: farming regions, where health problems existing for years have been intensified by war; small, quiet towns that have mushroomed overnight into close-packed centers around war industry and military

encampments; large cities where ordinary congestion has been aggravated by war activity.

Luxury Medicine

"Although there are areas critically in need of doctors because of withdrawals for the armed forces—a need frequently increased by expansion of the population for war industry—so far the health of the nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health.

"The number of communities critically in need of doctors is not great compared with the total number of communities in the United States. Those in need are, however, among those most vital to our war program.

"The voluntary relocation of physicians from communities where there is an abundance of doctors to areas in acute need of doctors has proved extremely difficult, and has not resulted in a solution to the problem.

"Luxury medicine, to which some Americans have become accustomed, is out for the duration. We can no longer afford to call doctors for imaginary ailments, and we must make the best and most efficient use of the medical facilities we have. . . . —San Francisco *Chronicle*.

Pennant to Identify Vehicles in Blackout

(COPY)

OFFICE OF CIVILIAN DEFENSE

Washington, D. C.

A uniform system of identification of emergency vehicles to enable them to operate during real or practice air-raid alarms was announced by the Office of Civilian Defense in Operations Letter No. 111, which is a supplement to Operations Letter No. 97.

The primary identifying device is a white pennant measuring 18 inches along each side with a 6-inch basic Civilian Defense insigne; that is, the letters CD in red inside a white triangle superimposed on a red circle. The pennant is to be attached to the left front portion of the vehicle.

To identify emergency motor vehicles at night, the Operations Letter further prescribes a headlight mask to be used over the right headlamp. This mask may be made of any opaque material that can be easily, quickly, and securely fastened to the headlamp. It is intended for use where blackout regulations permit the use of headlights; in coastal dimout areas it should be used in conjunction with dimout equipment. The design of the mask embodies the "CD" insigne 2½ to 3 inches in diameter in green.

Vehicles entitled to use the emergency identification include (a) vehicles of the armed forces of the United States or of her allies or other vehicles acting under orders or traveling with permission thereof; (b) vehicles of fire departments and governmental police agencies; (c) ambulances and rescue cars and other vehicles converted to such use in emergency services; (d) public utility repair vehicles operating in emergency service; (e) vehicles in emergency service as defined by State Civilian Defense authorities.

Use of the pennants and masks described was made mandatory for the 16 states and the District of Columbia in the Eastern Defense Command in an administrative order issued by the Director of Civilian Defense in accordance with the new Air Raid Protection Regulations which went into effect February 17. The Operations Letter recommends that all States adopt the definition of emergency motor vehicles and the methods of identification prescribed. Although many states have already adopted different methods of identifying emergency motor vehicles, it was urged that all states adopt the new devices. It was pointed out that a uniform system is particularly important in order that emergency motor vehicles which may be crossing state lines may not face unnecessary interference.

* * *

Transportation Plans for Civilian Defense

Transportation for casualties from scenes of disaster to hospitals and for injured persons or other patients removed from Casualty Receiving Hospitals to Emergency Base Hospitals are included in plans for emergency transport service during war disasters, described in recent Operations Letters issued by the Office of Civilian Defense.

Plans for local transportation are centered in the Transport Officer of the U. S. Citizens Defense Corps. It is the duty of the Transport Officer to maintain inventories of local equipment that can be used by the various emergency services of the Citizens Defense Corps, and he is responsible for organization, training, and supervision of volunteer drivers' units. Such equipment may include passenger cars, station wagons, motorcycles, ambulances, and other private vehicles. The instructions provide, however, that ambulances and cars or trucks used as improvised ambulances, with their drivers, should be assigned regularly to the Emergency Medical Service and be under its direction.

Through joint action of the Office of Defense Transportation and the Office of Civilian Defense, concurred in by the War and Navy Departments, local commercial motor vehicles, including taxicabs and trucks of small operators, which are now under the jurisdiction of the Office of Defense Transportation, have been released to and also are available to the Transport Officer for local service in case of war emergency. He may make use of such vehicles immediately, without application to the ODT.

For transport facilities needed outside the local area, such as might be required for evacuation of civilians or for transfer of injured persons to Emergency Base Hospitals in other cities or rural areas, the OCD and the ODT are coöperating in the organization of motor transport units in the larger common, contract, and private motor carriers of the critical areas of the country. These units, which will be trained in convoy service, will be provided by the ODT on request of the local Commander of the Citizens Defense Corps through the State Transport Officer and proper ODT district managers. ODT is at present developing an organization in the critical areas of the country under which its district managers will make contact with the local Transport Officers to make certain that each community is organized to function under the plan.

Operations Letter No. 114, issued March 3, which describes the above arrangements, urges coöperative planning between the Citizens Defense Corps and such agencies as the American Red Cross, the Women's Defense and Ambulance Corps, and local or state automobile associations or clubs, in order that several agencies may not seek to mobilize the same equipment and drivers independently, but may do so in coöperation. It is pointed out, for instance, that most local Red Cross chapters have permanent transportation committees to provide motor transport facilities for disaster relief. By coöperative planning, such facilities can be made available also to the Citizens Defense Corps.

Military Clippings.—Some news items of a military nature from the daily press follow:

Mental Unfits 5 in 13, Army Figures Show

Chicago, March 31.—(UP.)—Five of every 13 men reporting for induction in the armed services are rejected as mentally unfit, the American Medical Association said today.

It has been reported that 75 out of each 1,000 called by their draft boards were turned down last year because they were suffering from either mental or nervous disorders. Despite vastly improved methods in detecting such cases, approximately four out of each 100 manage to pass the screening tests and are admitted to the Army or Navy, only to be discharged later.

The rates were considerably higher in 1918, when seven of each 1,000 were discharged. Only 20 per thousand were rejected before their admittance, however, because doctors were unable to diagnose the disorders as satisfactorily as they have during recent years.

No blame is placed on any branch of the service for its acceptance of the mentally unsuited, but it is suggested that an increased study of the nervous diseases be made by physicians to provide a more accurate detection of such cases.—Long Beach *Sun*, April 1.

U. S. Doctors: Nation Faces Medical Problem as the Military Absorbs Supply

Washington, March 29.—(AP.)—About one-third of the Nation's doctors in full-time practice are now in the armed services, the Office of War Information said today in a warning that the medical situation "as a whole is not now out of control but unless remedial steps are taken soon it will grow progressively worse."

The OWI said that in too many cases physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population. It added:

"There are, however, enough doctors remaining in private practice to give adequate care to the civlian population, provided they can be properly distributed and according to special abilities."

The OWI said doctors now in the armed services total between 40,000 and 45,000 and as the additional physicians are called to military services "doctors in critical areas—many of them elderly—may succumb to exhaustion from overwork."

Refugee Doctors

The OWI also made these observations:

"In some communities local medical groups have resisted attempts to relocate outside doctors in their locality. In a number of instances (there was) disinclination of medical groups to allow a physician paid by the public health service to practice medicine in a particular community.

"A number of doctors questioned were against allowing refugee physicians to practice in their communities despite the obvious need for additional medical care.

"The system in use at present to apportion doctors between the armed forces and the civilian population is inadequate.

"In certain cases pressure was applied to doctors who were reluctant to enter the service. A quota was set in each state for the recruiting of doctors and the states were not supposed to go beyond those quotas. In many cases they did."

Explaining the scope of its report, the OWI said:

"OWI representatives traveled through the South, the Midwest, the West, the Eastern seaboard—in three distinct types of communities: Farming regions, where health problems existing for years have been intensified by war; small, quiet towns that have mushroomed overnight into close-packed centers around war industry and military encampments; large cities where ordinary congestion has been aggravated by war activity.

Luxury Medicine

Although there are areas critically in need of doctors because of withdrawals for the armed forces—a need frequently increased by expansion of the population for war industry—so far the health of the Nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are —most of them—working practically all the time and in total disregard of their own health.

Emphasizing the difficulties of relocating doctors to areas in need, the OWI said doctors who already had gone to war sometimes "and quite understandingly, show a definite antipathy to permitting outside doctors to come into their home communities and take over their practice."—San Francisco *Examiner*, March 30, 1943.

OWI Warns on Shortage of Doctors

Relocation of Civilian Physicians Urged as Health Measure

Washington, March 29.—(INS.)—The Office of War Information (OWI) today warned that with one-third of the Nation's doctors already in uniform, civilian health and working power will be jeopardized unless the present drain on the medical profession is halted immediately.

Following a survey of twenty states, OWI declared that *"the situation as a whole is not now out of control,"* although it reported these findings:

1. Most doctors are working practically all the time and in total disregard of their own health.

2. The number of communities critically in need of doctors is not great but those in need are among the most vital areas to our war program.

3. In too many cases, physicians were recruited for the armed services without sufficient regard for the welfare of the civilian population.

Legislation Implied

Although 40,000 to 45,000 doctors of the 135,932 registered in September, 1942, have gone into the Army, OWI declared that the remaining doctors would be enough to meet the Nation's needs if they were carefully distributed.

However, voluntary relocation of physicians would not solve this problem, the information agency declared, implying that only legislation permitting compulsory redistribution of the remaining doctors will remedy the situation.

OWI pointed out that in many communities the calls can be handled by fewer doctors than formerly were available.

Aid Suggested

The shortage also can be offset, it explained, by well instructed residents, by physically disabled interns who are unable to serve with the armed forces, by retired doctors, by those of the 8,000 women doctors who have not gone into service and by 6,000 refugee doctors.

There are now approximately eight doctors to 1,000 soldiers, whereas the War Manpower Commission's goal for civilians is one doctor to 1,500, said the OWI.

Epidemics Threaten

The survey listed some areas as having only one doctor to 5,000 or 6,000. Some of these sections, moreover, are crowded war industry areas, threatened by epidemics due to lack of sewage systems, inadequate sanitary facilities and questionable supplies of drinking water.

The medical profession has already taken some steps to ease the shortage in doctors, however, by establishing group clinics, pooling facilities and alternating their calls, the OWI reported. Some communities have brought in trained nurses to substitute for unobtainable doctors.

Coöperation Urged

OWI called on employers to coöperate by organizing medical care for their workers. It also urged physicians to coöperate fully with the state service programs which embrace a wide variety of medical treatment for chronic illness, hospital treatment and prenatal care.

"Luxury medicine, to which some Americans have become accustomed, is out for the duration," the OWI concluded.—San Francisco *Chronicle*, March 30, 1943.

Absence of Air Raid Shelters in Pasadena Surprises OCD Official

Question of Liability Not Raised in Other Cities, Says Dr. George Baehr, National Medical Director

Surprise that no public buildings in Pasadena had been designated as air raid shelters was expressed yesterday by Dr. George Baehr, director of Emergency Medical Services for the United States Office of Civilian Defense.

When informed at a press conference at OCD sector headquarters here that the question of liability had entered into the decision of Board of City Directors not to designate any shelters, Dr. Baehr said:

'Shouldn't Enter Into It'

"This question has not entered into the designation of shelters either abroad or in other parts of the country and should not enter into it here. In the cities on the East Coast there are designated shelters in each block in the business district. The question of liability has never arisen.". . .

Dr. Baehr stated that frequent rehearsals of air raids are held on the East Coast and that during these rehearsals all vehicular and pedestrian traffic ceases and the streets are cleared of persons.

He highly praised the new War Powers Bill which is now before the State Legislature as one of the finest

measures of its kind he had ever seen. This bill makes it illegal for any person unless engaged in the pursuit of civilian defense work to remain on the street or sidewalks after the air raid warning siren has sounded.

Organizes Defense Groups

The medical officer has just returned from Hawaii, where he assisted in organizing the various civilian defense groups which are taking over defense of the civilian population now that martial law is being removed.

"Protection of cities against destruction during a bombing attack is the problem of the civilian," Dr. Baehr said. "The Army will have its hands full and you cannot expect the Army to extinguish the fires, care for the injured and perform the hundred other duties of protecting the civilian population. It is up to each citizen to enlist in some type of civilian protection service and train himself to perform some useful function when the bomb-destruction during a bombing attack occurs."

The medical officer said that after his visit to Hawaii he was more convinced than ever that there would be an attack on the Pacific Coast.

'Can Expect Something'

"It is not at all impossible that we would either have sporadic raids or a concentrated attack on this coast," he warned. "When that happens it will be too late to prepare for it; we must prepare now.

"The Japanese have been awfully quiet recently and we can well expect something."

He expressed satisfaction at the progress that had been made by the civilian defense organizations, particularly the emergency medical services since his visit here a year ago.

"I think that you are as well prepared as you can be without having experienced an actual raid," he declared.—Pasadena *Star-News*.

Doctors' Households Urged to Set an Example in Waste Fat Salvage

The importance of saving waste household fats in order to salvage their glycerine content should be apparent to every physician. The doctor's kitchen, like that of every other family in town, can supply at least a tablespoonful of fat a day—from meat drippings, from rendered trimmings or fat skimmed from the soup kettles and no longer good for food. If that much were retrieved in every household and taken to the meat stores which collect the fat for the renderers, the amount saved would exceed the national goal of 200,000,000 pounds for 1943.

Why must we go to this trouble, in a land where more than a billion pounds of fat used to be wasted every year down the kitchen drain or into the garbage can? Because glycerine is desperately needed to feed the United Nations' war machine, and because many of America's outside sources of fats and oils have been cut off by the war.

Glycerine is indispensable in the manufacture of munitions, because it is the source of both nitroglycerine and dynamite, the first of which provides the explosives for propellants, and the second the means of military demolition. Tanks, ships and planes last longer because of paints containing glycerine. It is used as an anti-icing fluid for the propellors of fighter and bomber planes. The shock absorbers of jeeps and half-tracks, the recoil mechanisms of big guns and the firing mechanisms of depth bombs all contain glycerine.

Glycerine has an important place on the medical front, too, in both war and peace. It is one of the best known and widely used medical materials. There is scarcely a branch of therapeutics in which glycerine does not play a part. An average of more than three pounds of glycerine per hospital bed per year is used in our American hospitals. And an analysis of 15,063 prescriptions made prior to the war in a single American city showed that, with the sole exception of water, glycerine was the most-used liquid ingredient.

In military medicine the rôle of glycerine continues to grow. Even before we entered the war, large quantities of glycerine were shipped by the American Red Cross to England. In the requests made to organized medical groups in the United States for medical supplies, British authorities rated glycerine as equal in importance to surgical instruments.

Practically all the liquid sulfonamides call for glycerine. The war has given increased emphasis also to the long-established value of glycerine itself in burn therapy and surgical treatment, as well as for wound dressings. Dressings can be changed with less discomfort to the patient when they are soaked with glycerine.

The War Production Board is urging all Americans everywhere to help save the fat from which this precious liquid is made. The meat dealer from whom you purchase food will be glad to pay the prevailing rate for the kitchen fats YOUR household conserves. The pennies will buy War Stamps—and every pound of waste cooking fats turned in will provide enough glycerine to make a half-pound of dynamite or four 37-mm. anti-aircraft shells, or their equivalents in other badly-needed materials. Doctors, set an example in your community: start YOUR household saving waste kitchen fat today!—*Bulletin of Waste Fat Saving Committee.*

Veteran Hospital Plans Being Laid

Vast Building Program Mapped to Give All Who Saw War Service Free Medical Care

Washington, April 5.—Rough outlines for a program of hospitalization for veterans of the present war already are being sketched, Federal sources revealed today.

Studies to provide statistical foundation for a vast construction program have been begun as the result of broad legislation recently enacted by Congress assuring government-financed medical care for all persons—men and women alike—serving in the armed forces during the current conflict.

The new law, approved by President Roosevelt three weeks ago, assures the most generous treatment to American war veterans. Chief effect is to grant hospital privileges without regard to service connection for disability and to remove any sex discrimination.

Women Included

Manpower shortages, limitations on construction and lack of funds may delay the new program for many months, perhaps years. Yet steps are being taken to develop hospital facilities.

Under the measure, all hospitalization, clinical treatment and domiciliary care now available for veterans of World War I will be extended to any person in the military or naval service between Dec. 7, 1941, and the termination of hostilities. The statute specifically includes members of the "Waacs," "Waves," "Spars" and Marine Corps Women's Auxiliary.

Facilities Listed

As an emergency measure, the Veterans' Administration has notified all neuropsychiatric hospitals on the East and West Coasts they may exceed their rated capacity by 10 per cent in order to provide a limited amount of immediate treatment to servicemen suffering from mental disabilities incurred in the present war.

A recent survey shows that of a total of 2,446 beds in the General Hospital at Los Angeles, the Army has leased 1,004 and 400 cannot be used because of the manpower shortage. In the domiciliary quarters at Sawtelle only 1,977 of 3,346 beds are occupied now but the remaining facilities have been evacuated because of war conditions. At the San Fernando Tuberculosis Hospital occupancy during February averaged 349 of 364 available beds.—Los Angeles *Times*, April 6.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Resolution: Concerning Closer Coöperation between California Physicians' Service and Blue Cross Hospitalization Groups

The following was presented by the Resolution Committee to the members of the Association of California Hospitals, and unanimously passed February 25, 1943, in the meeting at Oakland, California.

WHEREAS, The present value of the voluntary hospital system in California will be maintained only through a widespread comprehensive and economical system of voluntary financing including Blue Cross Hospital Service plans, and

WHEREAS, The Blue Cross Plan Approval Committee of the American Hospital Association has recommended that Blue Cross plans "consider the possibility of expanding their services by merger with other Blue Cross plans which might serve their respective areas more effectively;" be it

Resolved, That the Association of California Hospitals go on record as approving and urging any steps

taken toward the merger of existing California Blue Cross plans to more effectively serve the citizens of the State of California; and further

Resolved, That it empower the Board of Directors of the Association of California Hospitals to confer with the existing California Blue Cross plans and the Blue Cross Hospital Service Plan Commission of the American Hospital Association towards obtaining this objective; and

WHEREAS, The public desires a service contract which includes both hospital and medical service care during hospitalization; and

WHEREAS, The success of both Hospital and Medical Service plans is dependent upon close coöperation between Physicians and Hospitals; therefore be it

Resolved, That all possible steps be taken to cement a close relationship with California Medical Association and California Physicians' Service to the end that a unified service be made available to the citizens of California; and further

Resolved, That a copy of this resolution be sent to the California Medical Association, California Physicians' Service, the three California Blue Cross Plans, the Hospital Conferences and to the Hospital Service Plan Commission of the American Hospital Association.

Medical Body Backs Hospital Fund Drive

To supply 800 more beds in over-crowded nonprofit hospitals, the Los Angeles County Medical Association is supporting the United Hospital Fund Campaign to raise $3,000,000.

Dr. E. Vincent Askey, president of the Association, states that there are only about half enough beds for residents of the city. Institutions entering into the drive include the Hollywood Presbyterian, Queen of Angels, St. Vincent's, Good Samaritan, California Lutheran, Methodist, and White Memorial Hospitals.—Hollywood *Citizen-News*, April 27.

United Hospital Fund of Los Angeles

The letter which follows was recently sent by the Directors of the United Hospital Fund of Los Angeles, to the physicians of that city:

(COPY)

Dear Doctor:

You are well aware of the acute shortage of beds in the voluntary hospitals in Los Angeles. This condition has been serious for several years. Now it is so critical it compels action. Unless steps commensurate with this need are taken now, our situation will grow increasingly desperate. There are no indications that in the future demands for hospital service will decline.

During the last five years, the population of Los Angeles has increased by 285,000. During the same time only 264 beds were added in our voluntary nonprofit hospitals. Assuming that our hospitals had sufficient beds to accommodate our population in 1937, and including the beds added since then, we would still need 591 more beds than we have to serve our increased population alone based on the recommended ratio of three general hospital beds per 1,000 population.

This is a situation which bears directly upon the health and safety of every Los Angeles resident. It is a problem in whose solution each one of us must share responsibility. But the need for increasing the capacity of our hospitals is of far greater interest and import to the members of the medical staffs of these institutions than to anyone else.

The reasons for this are obvious. Let us examine a few.

First. Medical men, being in daily contact with hospitals, see how desperate the shortage of beds is. The man in the street is aware of the problem only when one in his family seeks admittance to a hospital, while you are confronted with the problem of bed shortage daily in the normal pursuit of your profession.

Second. Because of your training and your keener appreciation of what adequate hospitals mean in the proper treatment of the sick and injured, you, more than anyone else, have an intellectual and moral obligation to assume leadership in any program for hospital improvement.

Third. While the average citizen has but an academic interest in hospitals, as he has in other cultural and welfare institutions, medical men have a heavy professional stake in their proper maintenance. It is true that our hospitals could not well operate without their medical staffs, but it is equally true that progressive doctors cannot practice good medicine without proper hospitals. Each is essential to the other. The hospital is the medical man's workshop.

After carefully analyzing the factors contributing to the inadequacy of our voluntary hospitals, exploring all the possibilities for overcoming these, and taking every possible step to increase the capacity of the plants as they now exist, a committee representing the boards of directors, the medical staffs and the administrators of eight voluntary hospitals have recommended a course of action which they feel to be the only solution to this problem. This solution calls for an intelligent presentation of the facts concerning our hospitals to the public, accompanied by a campaign for funds to enlarge these institutions.

For the purpose of this campaign, a corporation known as the United Hospital Fund of Los Angeles has been formed. The following institutions are members: California Lutheran, Good Samaritan, Methodist, Monte Sano, Hollywood Presbyterian-Olmsted Memorial, Queen of Angels, St. Vincent's and White Memorial.

The immediate goal of this fund-raising effort will be $3,000,000. This campaign will be the inaugural part of a long-range program, whose final objective will be the providing of hospital facilities for Los Angeles in keeping with the size of the community and the needs of its citizens.

The hospitals participating in this campaign will share in the results according to the following ratio which is based on their total average daily census for 1942:

Hospital	*Total Average Daily Census*	*Allocation*
California Lutheran	279.81	$450,000
Good Samaritan	308.0	630,000
Methodist	190.5	300,000
Monte Sano	51.2	87,000
Presbyterian	234.7	372,000
Queen of Angels	236.6	459,000
St. Vincent's	228.0	393,000
White Memorial	173.8	309,000

Contributors to this fund may designate the institution or institutions to receive their gifts. All gifts are deductible for income tax purposes.

Each hospital participating in the United Hospital Fund has submitted to the executive committee of the corporation, the objectives it hopes to realize with its portion of the funds raised. These include additional beds for general use, maternity beds, nurses' training schools, more clinical facilities and renovations to buildings and equipment. While the hospitals may deviate from these objectives, the fact that a joint committee has discussed the over-all improvement programs of the various insti-

tutions augers for a better coördinated hospital plan for Los Angeles in the future.

In this campaign, public-minded citizens of means, business and commercial houses, and corporations will be asked to contribute, in accordance with their interest in the community and their ability to give.

Because the men who use these hospitals are not only the best informed of the need, and because of their great professional equity in them, we feel that to succeed this project must first have the unqualified coöperation and support of the medical staffs. For these reasons we are now seeking your assistance.

With your intelligent leadership and generous financial support mobilized, this project can then be presented to the public with assurance of success.

Within a short time you will be given an opportunity to discuss this program at a meeting of your staff.

Plans for the solicitation of medical staff members will be initiated soon. Thereafter the appeal will be carried to business houses, corporations and selected individuals. We hope to have this fund-raising effort terminated by the end of June.

An undertaking of this magnitude will bring forth many problems—but none which cannot be solved with the full coöperation we know you will give.

Very truly yours,

DIRECTORS OF THE UNITED HOSPITAL FUND

Ritz E. Heerman, *Secy.*	Dr. Walter M. Holleran
Paul C. Elliott, *Treas.*	J. Frank Holt
W. L. Bradway	Otis A. Hudson
Howard Burrell	Roland Maxwell
G. H. Curtis	W. A. Monten
Colin M. Gair	Rt. Rev. Thos. J. O'Dwyer
Judge R. Morgan Galbreth	J. Howard Ziemann

By Th. R. Knudsen,
President, United Hospital Fund of Los Angeles.

San Francisco Hospitals

(As Seen "Behind the News," with Arthur Caylor):

Already, throughout Southern California, the hospital shortage is "desperate." Many sick people can't get beds. Increasingly, women are expected to have their babies in the Indian manner under a huckleberry bush—a system of self-service which antedates the cafeteria even in the Sunny South.

In this pinch, Los Angeles County's general hospital is preparing to take in pay patients—which is revolutionary—and Superintendent of Charities, Arthur J. Will has asked a Federal grant of $194,000 under the Lanham Act for 600 beds and 100 bassinets. He has a committee, which includes doctors, working on a plan to let pay patients be treated by private physicians—or by staff physicians under a scheme whereby the money would be used for research.

San Francisco is watching the Los Angeles experiment, my agents report. San Francisco Hospital could be expanded by 200 beds, according to Health Director Geiger. A big maternity ward could be established. Another 500 beds could be installed at Laguna Honda Home. But San Francisco apparently is waiting for the situation—and it's Wills who calls it "desperate"—to get equally bad here.

If that happens and it then develops that Uncle Sam acts with regard to hospitals at the same speed he has applied the Lanham Act to child nurseries, the theme song is likely to be that part of "Casey Jones" which runs: "Gonna get to Frisco but we'll all be dead."

Dr. Geiger frankly would like to avoid the complications sure to follow if pay patients are admitted to San Francisco Hospital. In the back of his mind has been the hope that San Francisco Hospital might do its part by taking the charity load off private hospitals. But information is that the private hospitals already are carrying a minimum of charity patients. Hence it appears possible that, before long, the Los Angeles system will be forced upon San Francisco—willy nilly. . . . —San Francisco *News*, March 12.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Extra Food Rations for Patients

In the April issue of California and Western Medicine, on page 216, brief editorial comment was made concerning Ration Order 13. The May number of the *Bulletin of the San Francisco County Medical Society* gives additional information and prints a form blank for a physician's statement, the use of which will save time for members of the medical profession and their patients. Explanatory statement and copy of form blank follow:

(Explanatory Statement)

Since the institution of food rationing, there has been some confusion in the matter of obtaining extra rations for patients requiring more than the regular allotment of foods.

Extra rations for patients on special diets are provided for by the Office of Price Administration Ration Order 13, article II, section 2.5, which is reprinted below.

The food rationing program is in its infancy and the lack of exact knowledge of the procedure necessary to obtain special rations has resulted in many incomplete and unsatisfactory requests being submitted to the ration boards. Likewise, the ration boards are faced with the problem of passing upon food requests based upon medical needs. In the attempt to produce a mutually satisfactory arrangement to facilitate the equitable distribution of extra rations to the proper patients, the San Francisco County Medical Society has appointed a committee to work with the San Francisco ration boards.

Your Society is printing a form (approved by the OPA, reproduced on page 9, designed to save the physician's time in prescribing extra food. This will make certain that all the essential information is presented. *The patient or his representative will be supplied this form at the time he calls at his local board for his regular extra ration application R-315.*

Ration Order 13, article II, section 2.5, reads as follows:

Consumers who need more processed foods because of illness may apply for more points. (*a*) Any consumer whose health requires that he have more processed foods than he can get with War Ration Book Two may apply for additional points. The application must be made, on OPA Form R-315, by the consumer himself or by some one acting for him and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon showing why he must have more processed foods, the amounts and types he needs during the next two months and why he cannot use unrationed foods instead.

(*b*) If the board finds that his health depends on his getting more processed foods and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional processed foods he needs during the next two months.

The application form referred to, OPA Form 315, is apt to be somewhat confusing to patients. It is titled "Sugar Special Purpose Application" and was developed primarily to meet the need for home canning. It is being used temporarily, until a more adequate form can be developed. The procedure indicated in section 2.5 may be changed somewhat in the future, in which case due notice is to be provided.

* * *

(Form Blanks for Patient and Physician)

Consumer's Application for Additional Foods to Be Filed At Local Rationing Board

Consumer's Request to His Physician

The undersigned consumer and patient hereby requests his physician to prepare and execute the following statement to be filed with the consumer's application (OPA Form R-315) to his Ration Board for additional ration points:

.....
(Signature of patient) (Address of patient)

.....
(Signature of patient's agent)

.....
(Address and relationship of agent, if any)

* * *

Physician's Statement

The undersigned.....is a licensed
(Print name of physician)
physician or surgeon.

....., aged about.....
(Print patient's name)
years, has been under my care for about.....
(Specify period)
and requires additional foods because such patient is suffering from.....
(Nature of illness)

I estimate that the amount and types of foods required by said patient each week for the next two (2) months is as follows: (Specify quantity of each food by weight and *specify alternate foods* for each food.)

(Insert items here)

Said patient cannot use any other foods for the following reasons:

(Insert reasons here)

.....
(Signature of Physician) (Office address)

.....
(Date) (Telephone number)

* * *

Advisory Medical Committee's Findings

The undersigned members of the Advisory Medical Committee have examined the patient's application for additional foods and the foregoing physician's statement and find as follows:

.....
.....
.....
.....
(Advisory Medical Committee)

Note: Rationing Regulations do *not* permit granting additional allotments of *coffee* to consumers for medicinal or other reasons.

The Physicians' Part in Food Rationing

The Bulletin of the Los Angeles County Medical Association, in its issue of May 6, 1943, also gave information concerning O.P.A. Ration Order 13:

To Members of the Los Angeles County
Medical Association:

The advent of food rationing has placed upon the medical profession the serious responsibility of prescribing food for persons, who, by reason of impaired health, must have more food than their allotment of ration points permits them to purchase. Within a few days after rationing began it was apparent that physicians, the public, and rationing boards alike were confused as to procedure. The Los Angeles Office of Price Administration therefore requested the Los Angeles County Medical Association to designate a committee of physicians who might both assist in clarifying procedure and advise rationing boards regarding prescriptions which seemed to them improper.

The provisions governing the prescribing of additional rationed foods appear in OPA Ration Order 13, Sec. 2.5 for "processed foods" and Ration Order 16, Sec. 2.4 for "meats, fats and oils." The provisions were identical, except for the reference to "foods covered by this order" and read as follows:

"Consumers who need more foods covered by this order because of illness may apply for more points.

"a. Any consumer whose health requires that he have more foods covered by this order than he can get with War Ration Book Two, may apply for additional points. The application must be made on OPA Form R-315, by the consumer himself or by someone acting for him, and may be made in person or by mail. The application can be made only to the board for the place where the consumer lives. He must submit with his application a written statement of a licensed or registered physician or surgeon, showing why he must have more foods covered by this order, the amounts and types he needs during the next two months, and why he cannot use unrationed foods instead.

"b. If the board finds that his health depends upon his getting more foods covered by this order, and that he cannot use or cannot get unrationed foods, it shall issue to him one or more certificates for the number of points necessary to get the additional foods covered by this order which he needs during the next two months."

A letter should be addressed to the patient's local rationing board. The following information must be given:

1. The name and address of the patient, and a statement that the patient is being treated or observed by the physician signing the request.

2. That in the course of such treatment or observation it is found that the patient must have more "processed foods" or more "meats, fats or oils," or more of both, than he can obtain with his regular ration book.

3. A detailed statement of the amount of "processed foods" or "meats, fats, and oils," or both, including the kind and weight of each type of food required for the patient's exclusive use for a maximum period of two months, in excess of the amount obtainable under the patient's ration book. Should the patient be permitted to choose from a variety of foods, such as meats, the physician may compute the necessary number of extra points needed, or express the need in terms of pounds needed for the two-month period. It is better to express the need for vegetables and fruits in pounds rather than in cans because of the variation in can sizes.

4. An explanation in detail as to why the patient must have more rationed foods for his health.

5. Why he cannot use unrationed foods instead.

6. An estimate of the probable duration of the patient's illness.

7. If an emergency, so state.

Physicians should inform themselves as to the kinds of food which are and which are not rationed. For example, the protein and fat requirements of a diabetic may be met in part by poultry, fresh fish, cottage cheese or cream cheese, which are not rationed at present. Processed foods, including canned fruits and vegetables, should not be prescribed unless an excellent reason exists for not using fresh foods.

Patients may request prescriptions for processed foods on the ground that they do not have time or facilities to prepare and cook the fresh product. In such instances, the doctor should state the facts on his prescription and allow the rationing board to decide whether the contention is valid. He should limit his own recommendation to the purely medical aspects of the case.

It is expected that one or more physicians in each area will be designated to act as advisors to rationing boards, in instances where prescriptions seem unreasonable, excessive, or unnecessary.

It is not the intention of the undersigned to advise any physician as to the kind or quantity of food which he should prescribe for any diseases or for any patient. Great pressure may be placed upon doctors by demanding and selfish patients who have no real need for additional rationed food. We suggest that such people be told that the food situation is serious, and that common decency as well as the OPA regulations make it quite impossible to prescribe extra food, unless a real and urgent medical reason exists.

COMMITTEE ON FOOD RATIONING,
HOWARD WEST, M. D.,
CARL HOWSON, M. D.,
E. T. REMMEN, M. D., *Chairman.*

Self-Protection Against Tularemia ("Rabbit Fever")

The following has been adapted by the Department of Health of the City of Los Angeles from the New York State Health News:

With the shortage of meat, it is likely that wild rabbits will be used for food more than usual this year. Since contact with wild rabbits gives rise to a certain risk of acquiring the disease tularemia, or "rabbit fever," hunters, housewives, chefs, and others who handle them, should again be reminded of the simple precautions which will guard against the infection. The following precautionary measures are suggested:

1. Leave the too-easily secured rabbit alone. If a rabbit is an easy shot, the chances are it is ill, and may be infected with tularemia.

2. Do not clean the rabbit if you have any sores, cuts or other lesions on your hands. Even if you have no lesions, it is well to wear rubber gloves when cleaning the rabbit and to wash the gloves thoroughly with soap and hot water before taking them off. Infection is usually acquired through contact with the blood or internal organs of rabbits and in almost every case which has occurred thus far in New York, there is a history of a cut or other lesion on the hand through which the infection apparently penetrated.

3. Be careful in the process of cleaning the rabbit not to cut yourself with the knife, puncture a finger on a broken rib, or in some other way cause a break in the skin.

4. Cook the rabbit meat thoroughly. The infection can be acquired by eating insufficiently cooked infected rabbit meat.

This warning is not intended to discourage the hunting of rabbits nor the use of rabbit meat. Such hunting is good sport and the meat obtained is a nutritious supplement to the diet, particularly valuable at this time of meat shortage.

The chance of acquiring tularemia from domestic rabbits is extremely small. For absolute safety, however, it would be good policy to follow the same precautions listed above.

A Venereal Disease Program

Recommendations for a Venereal Disease Control Program in Industry which follow, are from a Report of the Advisory Committee on the Control of Venereal Diseases, Otis L. Anderson, Chairman:

In order to assemble current authoritative information and to formulate basic principles applicable to a program of venereal disease disease control in industry, the Surgeon General has appointed an Advisory Committee to the United States Public Health Service. This committee has outlined the objectives of such a program as:

A. Medical and Public Health:

1. To find and refer for proper medical management all cases of venereal diseases among workers in industry.
2. To establish equitable policies for the employment of applicants and continuation of services of employees who have venereal diseases.
3. To coördinate the community and industrial venereal disease control programs.

B. Employee:

1. To improve the physical condition of employees.
2. To reduce the number of workdays lost through illness or injury.
3. To provide job placement.
4. To prolong and increase the earning power of employees.

C. Employer:

1. To reduce compensation costs.
2. To lessen work interruptions and labor turnover.
3. To enhance production by increasing the efficiency of workers.
4. To minimize personnel problems.

In order to assure agreement on all phases of fundamental policy, the committee recommends that certain agencies be consulted in carrying out this program: the State labor department, industrial commission or similar department of State government; the appropriate committee of the State medical society; the association representing employers; the labor organizations; appropriate voluntary health and welfare associations.

Responsibility for the administration of the program should be shared by the industrial hygiene and venereal disease divisions of the State health department. The program should not be inaugurated without a complete educational program. The employee should be convinced that adequate treatment protects both his health and his ability to earn a living, and the employer that not all cases of venereal disease are infectious, through an educational program before venereal disease control measures are introduced.

In order that the control program may be effective, preemployment examinations should be mandatory for all workers. Laboratory tests for syphilis and gonorrhea should be made a part of the periodic, reemployment or "return from illness" physical examinations which are the policy of the industry. The interval between examinations should under no circumstances be more than three years.

It is of utmost importance that the results of the medical examination be considered confidential between the worker and the medical staff. Information should be furnished to others only with the consent of the individual concerned or, failing this, on legal advice. The medical staff should make proper recommendations to the management as to the physical fitness of the employee for work. When the usual clinical record is kept in an open file, venereal disease forms should be filed in the medical department for the use of the medical staff only.

There is no reason for denying employment to an applicant or for discharging an employee because an examination has revealed evidence of syphilis or gonorrhea, provided:

1. That the employee agrees to place himself under competent medical management;

2. That, if the disease is in the infectious stage, employment should be delayed or interrupted until such time as a noninfectious state is established through treatment and open lesions are healed;

3. That when syphilis exists in a latent stage, employment should not be delayed nor interrupted;

4. That employment may be deferred or denied when the individual is an industrial hazard;

5. That occupational readjustments of employees be made of individuals developing disabling manifestations;

6. That workers with syphilis in any of its stages be excluded from areas where there is exposure to chemicals which may produce toxic reactions, and those having cardiovascular syphilis or neurosyphilis should not be exposed to physiologic stresses;

7. That workers with gonorrhea should be allowed to work only under special medical observation during the administration of sulfonamide drugs.

The applicant or the employee whose examination reveals evidence of a venereal disease should be called to the industrial physician's office for a conference. He should be instructed as to the nature of the disease which he has in order that he may coöperate intelligently with the requirements of the program. He should be referred to a reputable source for medical attention and be furnished with a letter directed to his physician stating the results of the examination and what is expected of the employee as to regularity of treatment if he is to be employed. The industrial physician should receive a record of treatment at about monthly intervals. The names of individuals who have neglected or refused treatment should be turned over to the health department for appropriate action in bringing them back to treatment.

The plant physician making a tentative diagnosis of communicable syphilis or gonorrhea should without delay acquaint the appropriate health authority with the facts.

Caution Concerning Substitutes for Glycerine

United States Department of Agriculture
Food Distribution Administration
Washington, D. C., April 6, 1943.

To All Consumers of Glycerine:

The present shortage of glycerine and the necessity of issuing available supplies for essential war needs has made it necessary to deny the use of glycerine in many instances. Many former users of glycerine, who are now unable to secure supplies, are using substitute materials where they are available.

In a recent memorandum addressed to all consumers of glycerine we discussed the reasons for our inability to allocate glycerine to all uses, as well as the methods for obtaining glycerine for approved end uses. We also mentioned in this memorandum the need of working out substitutes where possible. In using substitutes all consumers must investigate the toxicity of the substitute since it is an established fact that certain substitutes are definitely toxic. Among these toxic substitutes are:

Ethylene glycol
Diethylene glycol (diglycol)
Carbitol
Polyethylene glycol

and under no circumstance should these or other toxic substitutes be used in any product whether food, drug or cosmetic which is likely to be taken internally or otherwise absorbed by external application.

Furthermore, a number of proprietary glycerine substitutes have been offered for sale and before using them, inquiry should be made of the manufacturer in order to determine whether or not any of the above compounds or other toxic substitutes are present. When in doubt as to the use of any of these substitutes in food, drug, or cosmetic preparations, inquiry should be made of the authorities in charge of administering the Food, Drug and Cosmetic Law.

R. W. Capps, *Acting Chief*,
Fats and Oils Branch.

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Proposed Medical Liaison Office in Washington, D. C.

The letter and proposed resolution which follow, to be presented to the House of Delegates of the American Medical Association when it convenes in Chicago on June 7, 1943, may bring out much interesting discussion:

(Letter)

National Conference on Medical Service
April 8, 1943.

Dear Doctors:

Most medical society officials are well aware of the fact that extraordinary measures must be taken at once by organized medicine in the United States if the present high standards of medicine are to be maintained. The destruction of these standards will be a serious blow first of all to the general public and, secondly, to the medical profession. We are American citizens, the same as other groups, and we have a right to be represented and a right to be heard before any such steps are taken by those in whom constitutional authority is vested.

It is generally agreed that foremost among these extraordinary needs is a liaison office in Washington that will be in a position to offer timely, courteous and courageous advice and medical counsel to those whose duty it is to consider such matters. We have been repeatedly advised by men who are in a position to know that such advice will be welcomed. Such an office will bring the American Medical Association, as the representative of the medical profession of this country, in a much closer contact with official Washington than ever before. This will serve to protect both the patient and his physician from ill-advised political and economic experiments which ought not to be inflicted upon either the sick or the medical profession, either in time of war or in time of peace. . . .

The need for such an office that will be truly representative of the medical profession of this country has impressed itself upon medical men from every corner of the Union and the National Conference on Medical Service, which was held in Chicago on February 14, last, and

which Conference was made up of leaders in the medical profession from 29 states. . . .

All of us should be mindful that neither men nor time remain stationary. Either we go forward or we go backward. This is 1943 and the situations that confront us today are vastly different from those that confronted us twenty-five years ago. It should be noted in this connection that both the American Dental Association and American Hospital Association have decided to establish offices in Washington because they too appreciate that a mere official expression of principles will have little effect. Intelligent and authorized representatives of American medicine should be stationed there at all times, not only to give the advice that is so sorely needed but also in turn to be able to report to the medical profession of this country the activities of official Washington. At the same time we can keep a watchful eye on that other little group which expends so much of its time advancing the interests of cultism.

To effectuate similar action by the House of Delegates of the American Medical Association, numerous delegates from state societies are now planning to present the printed resolution enclosed with this letter. . . . Please study this resolution carefully and present it forthwith to your own local or state society. The time between now and the June meeting of the House of Delegates of the American Medical Association is short. We sincerely hope that you will submit it promptly to your House of Delegates or Council and that your society will instruct its Delegates to the American Medical Association to support this resolution when offered in June.

Respectfully yours,

W. L. Burnap, M. D., *President.*
C. L. Palmer, M. D., *Secretary.*

* * *

(Resolution)

A Resolution

To be presented to the House of Delegates of the American Medical Association at its next annual meeting in Chicago in June, 1943, for establishing a Committee on Medical Service.

Whereas, The medical profession is conscious of its responsibilities in providing timely and adequate medical services to all of the American people, irrespective of race, creed or financial status, and

Whereas, It believes it to be its duty and right to make available scientific facts, data and medical opinion with respect thereto, and to make known the rôle that the science and art of medicine plays in the daily lives of all Americans, and

Whereas, The medical profession of the United States is ready to offer constructive leadership in the advancement of medical principles that will further medical service to all of the people, and to preserve, not only the science and art of medicine, but the standards associated with the practice of medicine in America;

Now, Therefore, Be It Resolved, That there is hereby created by this House of Delegates a Committee on Medical Service which shall be composed of the following members:

1. The president of the American Medical Association, ex-officio.

2. The Immediate Past-President of the American Medical Association.

3. The Secretary of the American Medical Association, ex-officio.

4. A member of the Board of Trustees of the American Medical Association, designated and selected by the Board of Trustees.

5. One member of the American Medical Association elected as hereinafter provided from each of the following nine geographical subdivisions of the United States:

New England—Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut.
Middle Atlantic—New York, Pennsylvania, New Jersey.
East North Central—Ohio, Indiana, Illinois, Michigan, Wisconsin.
South Atlantic—Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Puerto Rico.
East South Central—Kentucky, Tennessee, Alabama, Mississippi.
West South Central—Arkansas, Louisiana, Oklahoma, Texas, Panama Canal Zone.
West North Central—Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas.
Mountain—Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada.
Pacific—Washington, Oregon, California, Alaska, Hawaii, Philippines, and Pacific Islands.

The members of this House of Delegates from each of the foregoing geographical subdivisions of the United States shall elect one member of the American Medical Association to serve on said Committee; three of said nine members shall serve for one year; three shall serve for two years; and three shall serve for three years; the respective terms of office of the nine members first elected shall be decided by lot and thereafter the said terms shall be for three years each. The expiration date for the first one year term shall be at the next ensuing annual session, of the House of Delegates of the American Medical Association. Expiration dates for all terms shall coincide with the dates of the regular annual session, of the House of Delegates of the American Medical Association.

Be It Further Resolved, That the duties of the Committee on Medical Service shall be:

1. The making available of scientific facts and data and medical opinion with respect to timely and adequate rendition of medical care to the American people.

2. To integrate the activities of the Committee on Medical Service with respective state and county committees on like activities.

3. Establish relationships and coöperation with other allied groups who are likewise engaged in the rendition of medical care, in its various branches, to the American people.

4. The Committee on Medical Service shall hold at least two meetings per year; one shall be held at the time and place of the Annual Meeting of this House of Delegates; the other meeting shall be held in the City of Washington, D. C., and called at the direction of the Chairman; and such other meetings as may be necessary to be called by the Chairman upon the written request of the majority of the Committee.

5. The Committee shall forthwith and annually thereafter elect from its own membership a Chairman and a Vice-Chairman.

6. The Committee on Medical Service shall establish and maintain an office in Washington, D. C., and shall further be empowered and directed to employ a full-time Executive Director, who shall act as Secretary of the Committee, and, whose duties shall be specified by the Committee. Such Executive Director shall be a physician who has been actively engaged in the private practice of medicine for not less than five years during the previous ten years, and furthermore, be informed and qualified to act as a Liaison Representative of said Committee.

7. The Committee on Medical Service is further authorized to hire such legal and administrative help as is necessary.

Be It Further Resolved, That the Committee on Medical Service shall submit a Budget for its expenses for the fiscal year to the Board of Trustees of the American Medical Association, and it is the consensus of opinion of this House of Delegates that the Board of Trustees shall forthwith appropriate not less than fifty cents nor more than one dollar for each member of the American Medical Association so that adequate funds will be available for such Committee to carry out its work on an honorable and ethical plane in keeping with the standards of American Medicine.

Be It Further Resolved, That this Committee shall submit an Annual Report to the House of Delegates at their Annual Meeting.

And Be It Further Resolved, That this resolution upon its adoption by the House of Delegates shall be forthwith transmitted to the Board of Trustees with the request that the Board of Trustees report back its action to the House of Delegates within twenty-four hours as provided for in the Constitution and By-Laws of the American Medical Association.

Work Suggestions for County Societies

Industrial Health.—Promotion of health among industrial employees is of vital importance at this time as a means of reducing absenteeism in plants producing war materials. The State Association is formulating a program on industrial health activities and will ask each county medical society to coöperate. Here is a big field and a real job for most local societies.

Maximum Utilization of Hospital Facilities

Efficiency Measures.—Although the field of hospital administration is in fact apart from the practice of medicine, still a bad community hospital situation will adversely affect medical and health services. Consequently, it would be wise for representatives of the medical society to coöperate with hospital officials to make sure that all hospital facilities are being utilized as efficiently as possible. Points to be considered in such a plan might include: elimination of "luxury" hospitalization; reduction of the time of hospitalization in certain types of cases; a survey of all beds in all community institutions for the care of the sick to determine if efficiency of utilization might be heightened through readjusting case loads, etc.; fullest possible use of nurses' aides and other lay personnel to release interns and residents and nurses for professional duties.

Increasing Bed Capacity.—In communities where such steps have already been taken the result has been a surprising increase in the availability of hospital facilities. One medium sized community found that it could increase its total bed capacity by more than 300 without purchasing a single piece of additional equipment. It did this by taking beds out of storage, placing additional beds in nonessential hospital floor space, and placing general patients in certain county institutions where the case load had dropped.

Wider Utilization of Nursing Services

It may be possible that the community's practicing registered nurses can assume certain tasks now being done by physicians, such as changing dressings, etc., under their direction, thus reducing demands for physicians' services. In at least one community, the local Red Cross chapter has made available the services of a graduate nurse for this purpose, and she has agreed to render such nursing care wherever it is recommended by the family physician. Close coöperation with nursing organizations should be maintained and their help solicited.

Utilization of Services of Health Department

Coöperation and Coördination.—Coördination of the services of the local health department and the services of the physicians in private practice is of greater importance now than ever. Many health department offices have personnel and facilities which would be extremely useful to the physician, especially if he finds himself swamped. The possibility of seeking the assistance of voluntary health agencies also should be explored.

Each Physician's Personal Obligation

Longer Hours, More Work.—It is obvious that the heavy demands of the armed forces for medical officers must result in greatly increased work for the physicians remaining on the home front. This added burden must be equitably distributed among all the physicians. Every physician at this time must provide all the medical service he is physically able to give. It may be necessary for some specialists to practice a limited amount of general medicine for the duration. It is necessary for physicians who have retired to resume practice and for those who have been devoting a limited amount of time to practice to carry on full working days. Local societies should drive home these points and try to work out means which will result in an equitable division of time and work among all doctors in the county.

Making Up Schedules.—Many physicians can improve the efficiency of their practices and help in conserving the time of patients as well as their own time, if they will do a better job of scheduling patients for office and home calls. For example, with help of his patients, a physician may be able to schedule house calls so he can see all patients residing in a certain section of the city or county in the morning and those in another area in the afternoon. Emergency calls must be made, of course, but certainly confusion in routine calls could be avoided through more efficient scheduling. Moreover, patients should be encouraged to see the doctor in his office whenever possible, thus saving time and providing an opportunity for the physician to make use of the services of his office nurse or attendant.

Miscellaneous Recommendations

Rationing Problems.—The rationing of automobiles, tires and gasoline presents problems which affect the medical and health situation to some extent. Medical and health services will break down unless the physician is provided with means of transportation. The county medical society should represent the medical profession of the county before rationing boards if serious problems arise. This could be done through the Committee on Medical Preparedness or a special committee established for that specific purpose. In bona fide cases of complaint, the county medical society's influence should be used in seeing that satisfactory adjustments are made.

Obstetrical Problems.—In one community the medical society conducted a pregnancy survey as a means of estimating future demands for obstetrical services and maternity beds in the local hospital. It should be a permanent and continuing project of the local medical society to maintain complete and reliable data about the medical resources of the county—hospital facilities and medical personnel. If breakdowns seem imminent, steps to correct the situation should be taken immediately—before the crisis occurs.

Official War Services.—The profession is obligated to assist the government in providing medical advice and services for war agencies such as Selective Service and Civilian Defense. All physicians should participate in these activities. The burden must be equalized. If only a few physicians take on these duties these physicians will not be able to devote sufficient time to their patients. This is unfair to those men and their patients.

Suggestions as to how some of the problems reviewed here might be handled or information as to how they are being met should be transmitted to the Headquarters Office, so they can be passed on to all county medical societies.

Providing civilians with necessary medical and health services is a responsibility of the medical profession under all conditions. Under wartime conditions the job is difficult but it can and will be done. No decrees, no administrative proclamations, no legislation, no compulsion will be necessary to tell doctors how to do the job on the home front, providing medical organizations take the initiative and the individual physician follows through. —*Item from an "Exchange."*

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (49)

Alameda County (4)

Garfield, Sidney R., *Oakland*
MacDonald, James L., *Oakland*
McDonald, Dorothy E., *Berkeley*
Moore, Richard W., *Oakland*

Butte-Glenn Counties (1)

Benninger, Concessa L., *Chico*

Fresno County (4)

Covington, C. H., *Madera*
Downing, William E., *Fresno*
Hof, Elmer A., *Fresno*
Weinberger, Herbert, *Ahwahnee*

Humboldt County (1)

Gianotti, Ernest Fiirst, *Scotia*

Imperial County (2)

Randolph, C. E., *Holtville*
Randolph, Harry L., *El Centro*

Kern County (3)

McNamara, Virginia P., *Bakersfield*
Patrick, Robert, *Bakersfield*
Savage, Emerson P., *Bakersfield*

Kings County (2)

Lees, Floyd E., *Hanford*
Lymp, Leo J., *Hanford*

Los Angeles County (7)

Foulk, Marguerite Lewis, *Los Angeles*
Gerber, Alex, *Los Angeles*
Lee, Henry Yen, *Los Angeles*
Page, Emery Phillips, *Alhambra*
Powers, Harry James, *Los Angeles*
Smith, C. Richard, *Los Angeles*
Swartout, Hubert Oscar, *Los Angeles*

Sacramento County (3)

Hemminger, George W., *Sacramento*
Perry, Herbert B., *Sacramento*
Ziph, Albert, *Sacramento*

San Bernardino County (2)

Heeres, Peter S., *Ontario*
Sterling, Allen F., *San Bernardino*

San Diego County (4)

Howell, William L., *San Diego*
Isham, Charles A., *San Diego*
Nelson, Max, *National City*
Oster, William B., *Ocean Beach*

San Francisco County (3)

Poulson, Theodore S., *San Francisco*
Sherman, Jr., Robert S., *San Francisco*
Tanner, Owel Ralph, *San Francisco*

San Joaquin County (2)

Fife, William S., *Detroit, Michigan*
Gale, Lester S., *Stockton*

San Luis Obispo County (1)

Bauer, Herbert, *San Luis Obispo*

Santa Barbara County (3)

Helbling, Franklin K., *Santa Barbara*
Olsen, Arthur R., *Santa Barbara*
Shorkley, Genevieve, *Carpenteria*

Santa Clara County (1)

Rehm, Mary Hoag, *Bethesda, Maryland*

Stanislaus County (3)

Maino, C. R., *Modesto*
Morrison, Alan F., *Oakdale*
Sherertz, Richard Charles, *Modesto*

Ventura County (1)

Nash, L. R., *Camarilla*

Yolo County (2)

Gray, John E., *Woodland*
Parsons, James E., *Dixon*

Transfers (11)

Jackson, Josephine A., from San Diego County to Los Angeles County
London, Milton Z., from Los Angeles County to Alameda County
Mann, Allan I., from Los Angeles County to San Diego County
Porter, Langley, from San Francisco County to Santa Barbara County
Wallace, John A., from Imperial County to San Bernardino County
Wilkinson, A. J., from San Diego County to Ventura County
Wright, Virginia L., from San Joaquin County to Lassen-Plumas-Modoc County

Retired Members (1)

Rowell, Hubert N., *Alameda County*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Fleming, Ernest William. Died at Los Angeles, March 7, 1943, age 81. Graduate of the University of Michigan Medical School, Ann Arbor, 1885. Licensed in California in 1889. Doctor Fleming was a retired member of the Los Angeles County Medical Association, the California Medical Association, and an Affiliate Fellow of the American Medical Association.

✣

Hambleton, Marcus Philip. Died at San Bernardino, March 16, 1943, age 63. Graduate of the Bowdoin Medical School, Brunswick-Portland, 1903. Licensed in California in 1921. Doctor Hambleton was a member of the San Bernardino County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARIES



Frank Roscoe Makinson
1885—1943

Frank Roscoe Makinson was born on a farm in Kansas, near the little village of Cedar, on September 1, 1885. There he was reared, alternating his time between school and farm until completing his high school studies.

As is the case with many farmer boys, farm and animal husbandry held no interest for Frank and he chose to follow the earlier occupation of his mother, who was an educator of other people's children before she concentrated her attention upon the rearing of her own group of nine, of which he was the youngest.

He graduated from the Kansas State Teachers' College and taught school for a short time. But another field called him. In Kansas he began premedical studies. These were interrupted for a short time by his coming to California, where they were resumed. Here he entered the Oakland College of Medicine and Surgery, where he graduated in May, 1913. At last his greatest ambition had been achieved, but his studies were far from complete. Inspired by the very enthusiastic faculty of the small medical school, the young graduate in medicine entered the hospital of the Sisters of Providence in Oakland, where he remained for a little more than three years before opening an office and entering private practice. Thus progressed Frank's long apprenticeship in the science and art of medicine which, properly, begins with one's premedical studies, continues through medical school and hospital, and extends to the evening of the last day of a doctor's professional career. During all of this period of active practice, he learns from book and scientific magazine, from great teachers and clinicians, from patients high in the affairs of men, as well as from the sick poor in the midst of their circumscribed opportunities and meagre surroundings.

All of these methods of study were followed with avidity by Dr. Makinson. Enthusiastic in the study of his chosen profession, he never sold the treatment of disease as merchandise.

He belonged to the county, state, and national medical associations, the California Academy of Medicine, and was a Fellow of the American College of Surgeons.

His interests were:—first, his family; next, his medical practice, and then he gave his remaining time and energy to the affairs of the medical profession itself.

In his service to medicine many honors—unsought—came to him: President and Councilor of the Alameda County Medical Association; President of the Public Health League of California; Councilor of the C.M.A. from the Seventh District (Alameda and Contra Costa counties); Chairman of the C.M.A. Committee on Public Health Education.

The arduous, time-consuming effort as Chairman of this highly important Committee began in 1940 and the final report of its activities he wrote during his last illness, bringing to a successful close a very important and laborious educational program.

During all of these activities he was the Medical Historian of the Alameda County Medical Association and gathered together much biographical data on the pioneers of our Association, as well as upon those who have passed our way in the intervening years.

What Dr. Makinson did for medicine was performed quietly, without fanfare or gesticulation and without any claim, expressed or implied, for reward or acknowledgment.

His devoted wife, Alice Bouchet, who was his right hand; a daughter, Mrs. Shirley Makinson Greig, and a son, James Thurston Makinson, M.D., recently graduated from the George Washington University Medical School and presently interning in Passavant Memorial Hospital in Chicago, survive him.

The gathering of friends, patients, and colleagues at his obsequies attested to the respect and affection in which he was held.

Perhaps if these attendant people could have given voice to their thoughts, they would have echoed the words of Steele written so many years ago: "There is not a more useful man in the commonwealth than a good physician; and by consequence, no worthier person than he that uses his skill with generosity, even to persons of condition, and compassion to those who are in want."

DANIEL CROSBY.

* * *

The esteem in which Doctor Frank R. Makinson was held is further evidenced by the resolution passed by the Assembly of the California Legislature in session at Sacramento, on April 23, 1943, and the action of the State Assembly in adjourning in his memory.

Assembly Resolution follows:

Resolution

The following resolution was offered:

By Messrs. Johnson, Carlson, Carey, Dickey, Sheridan, and Dunn:

House Resolution No. 207

Relating to Dr. Frank R. Makinson

WHEREAS, Dr. Frank R. Makinson of Oakland, came to his death on April 17, 1943; and

WHEREAS, Following his graduation from the Oakland College of Medicine and Surgery, Dr. Makinson devoted himself to the practice of medicine in Oakland for 30 years, was honored as a Fellow of the American Medical Association and of the American College of Surgeons, became President of the Alameda County Medical Association, and at the time of his death was a member of the Council of California Medical Association, representing Alameda County; and

WHEREAS, Dr. Makinson is survived by his widow, Alice Makinson, by a daughter, and by a son who is just finishing medical school; and

WHEREAS, It is the wish of the members of this Assembly by this resolution to give recognition to the distinguished service of Dr. Makinson to his community and to his profession, and to express their sympathy to Dr. Makinson's widow and two children; now, therefore, be it

Resolved by the Assembly of the State of California, That when this Assembly today adjourns it do so out of respect to the memory of Dr. Frank R. Makinson; and be it further

Resolved, That the Chief Clerk of the Assembly is requested to transmit suitably engrossed copies of this resolution to the family of Dr. Frank R. Makinson.

Request for Unanimous Consent

Mr. Johnson asked for, and was granted, unanimous consent to take up House Resolution No. 207, at this time, without reference to committee.

Resolution read and adopted by a rising vote of the Assembly.

* * *

Adjournment

At 11:43 p.m., on motion of Mr. Sam L. Collins, the Speaker declared the Assembly adjourned until 9:30 a.m., Saturday, April 24, 1943, out of respect to the memory of the late Dr. Frank R. Makinson.

C. William Queale, Minute Clerk.

✤

Margaret Schulze
1894-1943

On Sunday, February 14, 1943, death claimed Dr. Margaret Schulze, well known to this community as an able and conscientious woman who had become a gynecologist of national prominence, a talented member of the faculty of the University of California Medical School, a distinguished member of our Medical Society, a Fellow of the Pacific Coast Gynecologic Society, a Fellow of the American College of Surgeons, and a member of the American Board of Gynecology and Obstetrics.

Dr. Schulze graduated at the University of California in 1913 with the degree B. S., and in 1916 with the degree M. D. She served an internship in the Medical School in 1916, became an Assistant Resident in the Department of Obstetrics and Gynecology in 1917, and Resident in 1920 and 1921. Appointed Instructor by the University in 1921, she was promoted to Assistant Professor in 1931, serving competently and whole-heartedly in each of the many duties to which she was assigned.

While Resident, she became greatly interested in gynecological-obstetrical pathology, and gradually built up for the school a most satisfactory pathological museum, which served as the base for the excellent course in this specialized pathology which she conducted most ably for many years.

An unusually large proportion of gynecological admissions at the University of California Hospital are tumor cases, and these gave Dr. Schulze the opportunity of studying many atypical forms of neoplasms early in her career. Nearly twenty years ago she wrote the chapter on mammoth ovarian tumors in *Pelvic Neoplasms*, published by Appleton, which, to my mind, is as perfect a chapter on the subject as one could wish to see. For the first meeting of the Pacific Coast Gynecologic Society, in 1932, she presented a study of granulosa-cell tumors of the ovary, which is one of the first satisfactory papers on this subject in American literature.

All papers read by Dr. Schulze, for publication or not, were prepared most meticulously, whether for ward rounds, lectures, or for some medical society. They were written only after she had reviewed the entire literature of the subject, each item of which she herself read. When the paper was built on our own hospital records, she herself abstracted each individual case history and attempted to evaluate its worth. No wonder she was not a prolific writer. She learned, as Whitridge Williams taught, that proper preparation of one paper should consume the major part of one year. So papers written by Margaret Schulze will be sound reading for a long time to come.

While Resident Gynecologist, Dr. Schulze developed an excellent operative technique. She operated deftly and carefully. Her knowledge of pathology and her good common sense gave her unusually good surgical judgment in both gynecology and obstetrics. Students and Junior Staff Officers, who always recognize ability when they see it, brought their wives to her for advice and treatment almost in droves. Patient, gentle, and kindly, she cared for them no matter how it crowded her time. And as the years went by, she developed a clientele which loved her and was loyal to her every move.

No wonder, then, that when stricken in her 48th year, in comparative youth, she long since has been accorded national recognition as an able surgeon, a splendid teacher, an excellent author, and a sound pathologist.

Loyal, able, gentle almost to the point of shyness, she reflected from every angle the absolute intellectual honesty in which she lived and breathed.

Her passing creates a void in Pacific Coast Gynecology that will be most difficult to fill.

Frank W. Lynch.

✤

Ernest W. Fleming
1861—1943

Dr. Ernest W. Fleming died from carcinoma of the lungs, at his residence in Los Angeles, on Sunday, March 7, 1943, at the age of 82.

Dr. Fleming was graduated from the University of Michigan in 1885, had postgraduate general hospital training in New York City, ear, nose, and throat training later in Bellevue Hospital and the New York Polyclinic, thence to London and Germany. In Germany he worked under Schwartze, noted or his mastoid surgery.

Dr. Fleming settled in Los Angeles in 1892, confining his practice to the ear, nose and throat; the only specialist in Los Angeles who did so at that time.

Dr. Fleming was a founder member of the Los Angeles Ear, Nose and Throat Society and a member of the American Laryngological, Rhinological and Otological Society since 1899, also a member of the American Medical Association and the California Medical Association.

His brother specialists as well as the general practitioners had the greatest respect for Dr. Fleming's sincerity, courtesy and strong sense of professional ethics.

Hill Hastings, M.D.

✤

Montague Sydney Woolf
1883—1943

Few men have left a more lasting impression of gentleness, devotion, and friendliness amongst those who were closely associated with him than Dr. Montague Sydney Woolf, who passed away April 20th. He possessed the rare quality of making close friends and keeping them. He sought to help others and to do good, and his professional training assisted him in accomplishing his desire to alleviate suffering and to make the way happier for those with whom he came in contact.

Doctor Woolf was born in Plymouth, England, was educated in Birmingham, and with a scholarship in modern languages spent a year at Bonn and Heidelberg. But his true calling was medicine, which he studied at the University College Medical School of the University of London. He was granted a scholarship in Anatomy and Physiology, and received medals in Pathology and Clinical Surgery. In the World War he served in the Royal Army Medical Corps, as a civilian surgeon at army barracks in England, and in the British Naval Transport Service. As ship's surgeon he visited New York, where he left the Service at the close of the war, finally arriving in San Francisco.

In 1918, Doctor Terry appointed him Resident Surgeon at the University of California Hospital, with which institution he kept close association on the teaching staff and as visiting surgeon. In 1925, Doctor Woolf went to London, where he fitted himself to follow his specialty of proctology. His hospital connections besides the University Hospital were Children's, St. Mary's, and Southern Pacific. His publications in national and local journals were largely on subjects connected with his specialty, but his general training qualified him to write a text-book: "Principles of Surgery for Nurses," which was published in 1925.

While those of us who knew Monty best feel keenly his absence from our midst, we shall treasure memories of his fidelity and gentle manliness, and shall miss grieviously his "Cheerio."

RICHARD W. HARVEY, M.D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. F. G. LINDEMULDER.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

A program dealing with "Wartime Medicine in the South Pacific" was heard by members of the Alameda County Medical Auxiliary when they gathered at the Rock Ridge Women's Club for their regular April meeting.

Lt. Robert Dennis Lee, Medical Corps, U. S. Navy, spoke on "The Practice of Medicine Under Combat Conditions." Dr. Lee has been on active duty with the fleet for the past year. Lt. Beth Veley of the Army Nurse Corps, one of the last persons to leave Bataan before its fall, gave an interesting account of the care of the sick and wounded and of their escape from Bataan.

The benefit parties given by individual Auxiliary members for the Philanthropic Fund have proved very successful. Among members who have entertained for this purpose are Mesdames T. Floyd Bell, Hobart Rogers, Roy Nelson, Albert Boles, Wallace Partch, C. J. Lundsford, T. C. Lawson, Charles DeVaul, S. M. Babbington, L. R. Jacobus, W. O. Solomen, Walter Rapapport, LeRoy Hahn, Grant Ellis, Harold Lambert, Kenneth Thompson, John Blum, E. Greer, and Henry Mankin.

The March meeting of the Marin County Woman's Medical Auxiliary was held at the Travelers Inn, in San Rafael. Mrs. R. B. Hartman presided.

The speaker for the evening was Mrs. Sigrid Clark, who discussed the functions of nurses' aides and told what a splendid work these women are doing in Marin County.

At a business meeting following dinner, it was decided to have members of the Auxiliary serve at the U.S.O. house for several days in April.

Because of the large area included in the Los Angeles County Auxiliary, Long Beach, Glendale, and Pasadena each conduct their own meetings. Once a year, however, each one is hostess to the entire group. Long Beach members were hostesses at the Pacific Coast Club in Long Beach.

Speaker of the day was Mr. Boyd Comstock, whose topic was "Italian Reaction to Nazi Domination." Mr Comstock, formerly athletic coach at the University of Southern California and at Yale University, was recently with the Italian Government in their program for the Development of Young Italian Athletes. He returned to the United States last fall on the exchange ship, "Drottingholm."

Hostesses for the day included Mrs. Ralph Eusden, Mrs. G. Raphael Dunlevy, and Mrs. Horrace McCoy Mrs. Franklin Farman, President, presided.

Dr. Henry Newman, Assistant Professor of Neuropsychiatry at Stanford University Hospital, gave an interesting talk on "Clinical Effects of Alcohol and Safe Driving," when the Woman's Auxiliary to the San Francisco Medical Society held their regular March meeting.

At the business meeting, the report of the Nominating Committee was read, and the Officers and Directors were elected. Plans were discussed for the Annual Benefit Bridge Party which is given each year for the Student Loan Fund. Mrs. Norman Morgan, Hospitality Chairman, arranged the tea, assisted by Mrs. William Reilly and Mrs. Frederick Fellows. Guests of honor were wives of doctors in the armed forces.

This year the Medical Auxiliary has been one of the many National and State organizations that has coöperated in the Cancer Control Educational Program of the Women's Field Army of the American Society for the Control of Cancer, Inc. Mrs. F. G. Lindemulder, the California State President of the Medical Auxiliary, has served as a member of the State Advisory Board to the Women's Field Army. Mrs. Kaho Daily was appointed as State Chairman to represent the Auxiliary.

Throughout the State the County Auxiliaries have helped in various ways. Some have made donations. Auxiliary members have served as officers or helped in the distribution of literature and helped in the street drives, and too, they are helping in the War Service Program.

The annual April membership campaign was preceded by a tea given in the home of Mrs. Clifford Andrews Wright, in honor of the State and County Executive and Advisory Board members, also the Advance Gifts Committee Chairman. Mrs. Wright is Honorary Commander of the Los Angeles County Division and serves as a member of the State Advisory Board.

Four hundred fifty high schools were contacted in the State, and suggestions were made that through the science, biology or health courses, accurate general information be obtained from representatives of the American Society for the Control of Cancer in their community, and that it be used in classroom discussion.

A five-hundred-word essay contest was sponsored among California high school students on the subject, "Fight Cancer With Knowledge." A twenty-five dollar war bond is to be offered for the best essay submitted.

Over one hundred junior colleges, colleges, and universities have been stimulated to obtain scientific material in the form of pamphlets, books and films.

As a part of the War Service Program, in response to requests from the Red Cross Chapters, a brief talk on the care of cancer patients was prepared for instructors, to be included in their lectures to the Volunteer Nurses Corps and the Home Nursing course. Small organized groups have been making surgical dressings to be distributed to unhospitalized cancer patients.

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

The April issue of two hundred and forty-six magazines throughout the country have again made a tremendous contribution by donating space for announcements, editorials and special articles.

In California the physicians have coöperated by serving as members of the State and County Executive Committees, lecturing, writing articles and giving radio talks; in general, guiding this Educational Program in order to keep it within the standards of scientific medicine.

The educational progress in cancer control is basically one of personal contact and personal participation. At the annual National Board meeting in New York, there was a general agreement as to the desirability to adhere to the previously established policy in the Cancer Control Educational Program to emphasize the hopeful side of Cancer.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (March, 1943)		42,600
Rural Health Program		5,000
War Housing Projects (approximate)		41,000
Marin	6,000	
Los Angeles	7,500	
San Diego	12,500	
Vallejo	15,000	
Total		88,600

The program of converting the full coverage membership to the New Two Visit Deductible and Surgical Plan is now 75 per cent complete. There has been no significant loss of membership as a result of the conversion, and in the main, beneficiary members recognize the necessity for the change and have accepted the situation without resentment. We find the surgical coverage for dependents has received wide acceptance.

During the past year, turnover in employment has been very rapid, and as a result our cancellation rate among members changing to new jobs has been very heavy. Nevertheless, we have been able to more than hold our own, even though the net increase has been small. Naturally, acquisition expense ratios in relation to continuous membership have increased. It has been difficult to find and retain competent administrative and office personnel, and higher wage rates are prevalent in all levels.

In spite of these difficulties, however, the new form of membership is returning a better compensation to professional members. Following is a review of unit values paid during recent months:

July, 1942	$1.30
August	1.30
September	1.40
October	1.40
November	1.40
December	1.50
January, 1943	1.60
February	1.75

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

CALIFORNIA PHYSICIANS' SERVICE
A Nonprofit Corporation
153 Kearny Street, San Francisco
IMPORTANT MEMORANDUM

To: Physicians and Nurses—

Certainly we all know that California Physicians' Service has found the going difficult during the past four years. We believe that most of the faults have now been corrected and that you will be interested in a brief report of C.P.S. activities, because they affect you and the rest of the medical profession throughout the State.

1. C.P.S. started operations in 1939 with a full coverage contract. We have found that this type of contract was difficult to administer, and that under it the plan has been subjected to excessive use of service by a minority of beneficiary members, with the end result that the doctors received very little for their services. In the summer of 1942, we developed a much simpler 2-visit deductible plan, and have already converted approximately 80 per cent of the full coverage contracts to the new plan. The contracts of the remaining members will be converted within the next two or three months.

This new plan has corrected many of the defects of the old plan, and has eliminated most of the complaints and problems of doctors and beneficiary members. Since the start of this conversion program in September of 1942, the unit value has increased 36 per cent, and we confidently expect further betterment. The conversion to date has been accomplished without any significant loss of membership.

In the new 2-visit deductible plan, you are to charge the member your usual fee for the first two visits, just as if he were a private patient. If x-ray, laboratory tests or surgical operations are necessary during the first or second visit, their cost will be paid from the C.P.S. fund. Continued treatments beyond two visits and beginning with the third visit will be payable from the C.P.S. fund.

Our enrollment efforts are concentrated upon this 2-visit deductible plan, and upon the surgical plan, and we are pointing our efforts directly to the "lower income groups"—that is, where family incomes do not exceed $3,000.00 per year.

2. Since 1941, many thousands of new families have moved into California from all parts of the United States to find employment in the enormous war industries that have been built up here. In order to provide housing for these families, the federal government has built temporary housing adjacent to these war industries. However well this action has solved the problem of housing, it has created new problems, most important of which is the lack of adequate medical care. This difficulty was further aggravated by the withdrawal of doctors from these communities to fill the needs of the armed services. Other districts of the State could not spare sufficient individual physicians to relocate themselves for practice in or near these housing projects.

There seem to be several alternative methods of solving this problem:

a. The United States Public Health Service could secure physicians (in effect, through the draft), put them in uniform and on salary—straight government medicine.

b. Employers in the industries in which these people were employed could set up their own plans, as Mr. Kaiser did, with physicians on salary.

c. Profit-making health service organizations could contract to furnish care—with physicians on salary.

d. Or the medical profession itself, through its own service organization (C.P.S.) could undertake the job, employing physicians to furnish services necessary on the

projects, and referring patients who required more extensive work or hospitalization to the C.P.S. professional members of the local communities, whom the patient may select.

Faced with this practical and very urgent and pressing situation, the Board of Trustees of C.P.S. felt that it was better for the medical profession to undertake the job itself, thereby controlling standards of service and preserving as much as possible of free choice and the valued patient-physician relationship. Before C.P.S. had entered into agreements on any of these projects, the local County Medical Society and the physicians of the community were consulted and their approval obtained—and not only their approval, but their coöperation in the administration of the service. Income from these projects has been kept separate from regular C.P.S. funds, and so far the operation has returned a unit value ranging between $1.75 and $2.50 to the local professional members.

In these undertakings we have had the utmost of cooperation from the Federal Public Housing Authorities, from the United States Public Health Service, the Procurement and Assignment Service and from the Council of the California Medical Association. Unofficially, Federal officials say that California is the only State in the Union in which the organized medical profession has set up a better solution for the health problems of these congested areas than the Government itself had hoped to supply. A directive has been issued by the War Department that all officers and civilian heads of departments should contact health service plans in their communities and give every assistance to the enrollment of civilian employees of the War Department, so that they may budget the cost of their illnesses through these channels.

3. Today C.P.S. has approximately 5,200 professional members. We will do our best to keep you and your office staff informed as to the activities and developments of this doctor-owned organization. There are several compulsory health bills up before the State Legislature at this session, which if passed would have a definite effect upon the practice of medicine in California. The numbers of these bills are S.B. 885 and A.B. 1079. Your continued support of C.P.S. is the best instrument with which to combat such compulsory legislation.

If there should be any questions regarding our activities or procedures, please call or write our office. We appreciate your coöperation, and we assure you of ours at all times.

Sincerely yours,
California Physicians' Service.

* * *

California Physicians' Service
153 Kearny Street
San Francisco, California

Dear Doctor:

We intend to give you, each month, a brief report of the activities and operations of California Physicians' Service. In last month's statement to you, a folder describing the benefits to employed groups was enclosed. Many doctors have written for an additional supply so that they can be given to their "lower income patients." California Physicians' Service is developing its membership in groups whose family income is less than $3,000.00 annually. We will appreciate any help you can give us in securing more of these groups. . . .

Again in January the "unit" for medical service increased in value. Our two-visit deductible medical and the surgical contracts are partly responsible for this increase.

Financial operations for the month of January were as follows:

Dues collected	$45,169.80
Late dues and unused portion of prior allocations	2,564.32
Professional Member dues	75.00
	47,809.12
Cost of Administration	11,306.60
Available for January business	36,502.52
X-ray and lab. on hospitalized patients	3,172.50
Available for remaining professional services	33,330.02
20,095.1 units of service, at $1.60	32,152.60
Transferred to Unit Stabilization Fund	1,177.42
Previous balance in Fund	29,538.67
Total Unit Stabilization Fund	$30,716.09

A. E. Larsen, M. D.
Executive Medical Director.

March 22, 1943.

* * *

Medical Center to Be Pattern For Projects

The Harbor Gate project in Richmond will be the first of California's housing projects to create medical services patterned on Marin City's medical center, stated William Reidy, State medical services coördinator for the FPHA.

Marin City's prepaid medical plan is operated by the California Physicians' Service, and assures complete care for all members of the family.

Focal point of the plan here is the Medical Center. It is staffed by the adult doctor, Dr. Julius Alsburg; pediatrician, Dr. Myrl Morris and three office nurses and one home visiting nurse.

When the new Center building is completed, it will include space for a 12-bed women's and children infirmary.

Health defenses at Marin City also include the Well-Baby Clinic, held bi-monthly at the Community Building. This service was initiated by the Marin County Health Department under the direction of Dr. Irving Johnson.

"Sixty thousand out of 150,000 doctors in the United States are being taken into the armed forces," said Reidy. "Marin City residents are fortunate that their medical care assures them of the services of two doctors, who cannot be taken away before replacements are made." —Sausalito *News*, March 11.

California Physicians' Service: Two Letters

In a recent issue of the Bulletin of the *Los Angeles County Medical Association* appeared two letters by Doctors Madeline J. Algee and Alson R. Kilgore, dealing with activities of the California Physicians' Service.

(Letter of Doctor Algee)

January 4, 1943.

Editor, The Open Page of the Bulletin of the Los Angeles County Medical Association:

The predictions of the ignored majority of the State Medical Association have come to pass. The California Physicians' Service plan was urged upon us by a minority faction with the promise that it would prevent exactly the situation stated in *Medical Economics*, December, 1942, to have been established by California Physicians' Service with the approval of the State Medical Association in Marin City. Fees for medical care are being collected with the rent and physicians employed on salaries ranging from $300 to $600 a month are being hired by California Physicians' Service to care for the 40,000 workers and their families.

Is it no longer illegal for corporations to practice medicine?

The California Physicians' Service has advertised widely that it is sponsored by the California State Medical Association, but it is in no way controlled by it and differs in no way whatever from any other corporation which employs physicians on salaries and collects fees for their services from patients. Is this not what the State Medical Association has aimed to prevent? Have we been betrayed?

Please, State Medical Association, explain this away.

MADELINE J. ALGEE, M. D.
508 N. Long Beach Boulevard, Compton, Calif.

* * *

(Reply Letter of Doctor Kilgore)

March 15, 1943.

Editor, The Open Page of the Bulletin of the Los Angeles County Medical Association:

The letter from Dr. Madeline Algee on your "Open Page" of January 21st may already have been answered. But if not, may I do it? Because at least the main question raised is an entirely proper one and deserves an answer.

She states that California Physicians' Service is in no way different from any other corporation employing physicians on salaries and asks if by so employing physicians to serve in health centers on war-industry housing projects the rest of the doctors in California have not been "betrayed." Is this not, she asks, exactly the situation that a "minority faction" promised the "ignored majority" C.P.S. would prevent?

In the first place, C.P.S. is not, by any stretch of imagination, the same as any other corporation. It is 5,500 physicians of California organized to provide service to its beneficiary members under the changing conditions of medical practice. Its services and its methods of operation are directly under the control of those physicians through their elected administrative members and the Board of Trustees.

In the second place, probably none of us on either side of the C.P.S. debate of 1938 foresaw "exactly the situation" of thousands of war workers and their families, concentrated in new housing projects with no medical care on the projects and quite inadequate medical care in nearby towns (3,600 people live at Marinship today and this number is rapidly increasing. Sausalito, the only adjacent town, has three physicians, already busy in the town itself.)

If one will ask himself what he would do as a member of a housing authority, responsible for reasonable facilities in these new communities, the answer is, he would see to it that, in some way or other, medical care is made available.

Waiting for individual physicians to establish themselves for practice in or near these housing projects is impossible. So far, to my knowledge, no physician has even offered to try it.

There are alternative methods. The U. S. Public Health Service could secure physicians (in effect through the draft), put them in uniform and on salaries—straight government medicine. Employers can set up their own plans, as Mr. Kaiser did, with physicians on salaries. Profit-making health service organizations could contract to furnish care—with physicians on salaries. Or the medical profession, through its own service organization, C.P.S., can undertake the job, employing physicians to furnish service necessary on the projects and referring patients who require more extensive work or hospitalization to any C.P.S. Professional Members whom the patient may select. But there is no alternative to the employment of physicians by someone or some organization.

Faced with this practical and very urgent and pressing situation, is it better that the government or a private contractor take these people entirely away from the medical profession as patients or that the medical profession undertake the job itself, controlling standards of service and preserving as much as possible of "free choice" and the valued patient-physician relationship?

Finally, before any of these projects has been entered upon, the local County Medical Society and the physicians of the community were consulted and their approval obtained and not only their approval but their coöperation in the administration of the service.

These being facts, words like "minority faction," "ignored majority" and "betrayed" seem fairly uninformed to those who know the problems and the dangers to medicine inherent in their non-medical solution.

Very sincerely yours,

ALSON R. KILGORE, M. D.
San Francisco, Calif.

MEDICAL EPONYM

Milroy's Disease

William Forsyth Milroy (b. 1855), professor of clinical medicine and hygiene in the Omaha (Nebraska) Medical College, read a paper entitled "An Undescribed Variety of Hereditary Oedema" before the Society of the Alumni of Charity Hospital on June 1, 1892; this was published in the *New York Medical Journal* (56:505-508, 1892). He described the condition as follows:

"On August 20, 1891, Mr. H. presented himself for examination for life insurance. . . . The applicant called my attention to his lower extremities. I found a condition of oedema involving the feet and extending up the legs to the knees. . . . Upon inspection, the leg presented a slightly rosy hue. . . . Scattered thickly over this base were white spots about the size of a pea. . . . Mr. H. stated that this oedematous enlargement had existed from birth. . . . that this enlargement of the extremities was a family characteristic which he had inherited from his mother. Fortunately for the purpose of this study . . . in 1883 a member of the family published a neat volume, giving the family history in America for a period of two hundred and fifty years. . . . The peculiarity now under discussion seems to have entered the family by marriage about 1768. With the aid of this volume and the assistance of members of the family still living, I am able to offer the facts which I present. . . .

"1. So far as known, in every case, with two exceptions only, the oedema was present at birth.

"2. The location of the oedema has in every case been limited to one or both lower extremities.

"3. The presence of the oedema is persistent, never having been known to disappear, temporarily or permanently, except in one instance.

"4. It has never been attended by constitutional symptoms, barring the two possible cases in which its first appearance was subsequent to birth.

"From these considerations it seems evident that the case under discussion is not one of angeio-neurotic oedema. . . . Whether or not the case is one of nervous edema, it is offered that, with others, sufficient material may be accumulated to render possible study of these unusual forms of oedema.—R. W. B., in *New England Journal of Medicine.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Place and date of the 73rd Annual Session, to be held in 1944, to be announced later.

1 1 1

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

During the month of May, the broadcasts will be given on the following Saturdays: May 1, 8, 15, 22 and 29.

KFAC presents the Saturday programs at 8:45 a. m., until the title, "Your Doctor and You."

The Saturday broadcasts of KECA are given at 10:30 a. m., under the title, "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m. Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Books Roll On:* Oleanders (Galveston orchids), to A. W. Ham and M. D. Salter of Toronto for their skillful *Doctor in the Making: The Art of Being a Medical Student* (Phila., Lippincott, 1943). Ditto to Y. Henderson and H. Haggard for a concise 2nd edition of their standard *Noxious Gases* (Reinhold, N. Y., 1943). Ohio State University Development Fund, Columbus, announces English edition of Paul Bert's classic *Barometric Pressure,* by M. A. and F. A. Hitchcock, at $9.00 prepublication. W. S. Cutting offers a *Manual of Clinical Therapeutics* (Phila., Saunders, 1943). R. D. Herrold briefs the *Chemotherapy of Gonococcic Infections* (St. Louis, Mosby, 1943). I. Galdston gives a popular peek *Behind the Sulfa Drugs: A Brief History of Chemotherapy* (N. Y., Appleton, 1943), which isn't as informative as M. Silverman's chapters in his *Magic in a Bottle* (N. Y., MacMillan, 1941). C. C. Thomas of Springfield, Ill., offers A. Coca's *Familial Nonreaginic Food-Allergy,* and the *Medical Progress Annuals.* P. Wylie's *Generation of Vipers* (N. Y., 1942), makes me wonder. W. Saroyan's *Human Comedy* (N. Y., 1943), makes me wishful. J. Fortune and J. Burton's *Elisabet Ney* (Knopf, N. Y., 1943), illustrates many of the points of K. Menninger's *Love Against Hate* (N. Y., 1943), and gives the lowdown on old Texas.

2. *Nature:* (the magazine), like Univ. of California, celebrates its 75th birthday, and properly notes centenary of MacMillan, its publisher. In recent issues: P. C. Koller shows increased rate of cell division due to quantitative change in nucleic acid synthesis (151:244, February 27, 1943); B. Macgraith, G. M. Findlay and N. Martin (in West African Force), find evidence for red cell lytic enzyme usually held in check by inhibitors in tissues and plasma (*ibid.,* p. 252). P. B. Medewar, et al., find 8-hexenolactone inhibits fibroblastic growth but not epithelial (*ibid.,* p. 195). J. Barcroft, et al., come back brilliantly by finally showing that sodium acetate is used by mammalian heart and at about same rate as glucose (*ibid.,* p. 304, March 13, 1943).

3. *Medicine:* (the magazine), comes across with 3 good reviews in February issue (Vol. 22, No. 1): D. McEachern on thymus in relation to myesthenia gravis; R. Ottenberg and R. Spiegel on nonobstructive jaundice due to chemicals, and G. Martin and M. R. Thompson on intravenous alimentation with amino-acids.

4. *Public Health:* The scientific question about vitamins contributing to physical fitness is finally answered affirmatively by A. A. Harper, et al. (*Brit. Med. J.,* 1:243, February 27, 1943). C. A. Mills shows positive correlation between urban air pollution and incidence of respiratory diseases (*Amer. J. Hyg.,* 37:131, 1943). Say, maybe we have to do more fighting on the home front in this war: Don't we need lots of people with brains and ability to help reduce the alarming increase in preventable diseases like tuberculosis, pellagra, diphtheria, spotted fever, mental disorder, and especially venereal disease?

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

5. *Otherwise:* From Lima, Peru, comes the new *Revista de Medicina Experimental,* with C. Gutierrez-Noriega's report on the medullary vasoconstrictor center. O. H. Robertson (*Science,* 97:142, 1943), says triethylene glycol is the best of all glycols for sterilizing air (1 mgm per 200 liters of air—0.1 c.c. per 800 cu. ft.). J. J. Lalich and A. L. Copley (*Arch. Surg.,* 46:224, 1943), note that dicoumarin doesn't much decrease clot resistance in wound thrombi. Australian Committee on Survey of War Medicine has excellent review on treatment of burns (*Suppl. 7, Med. J. Austral.,* January, 1943). H. O. Calvary and crew begin work on bacterial pyrogens (*J. Amer. Pharm. Asso.,* 32:65, 1943). D. Court and S. Taylor find pitressin tannate suspended in peanut oil effective on single intramuscular injection in controlling diabetes insipidus for many days (*Lancet,* 1:265, February 27, 1943). C. H. Rammelskamp and C. S. Keefer find penicillin absorbed and excreted more rapidly after intrathecal injection in meningitis patients than in healthy humans, and wish less untoward effect (*Amer. J. Med. Sci.,* 205:342, 1943). Vale to Edgar Allen using colchicim to produce cellular mitosis to study differential growth in ovaries of rats (*Amer. J. Anat.,* 72:291, 1943).

Napa County Medical Society Meeting at Napa State Hospital, Imola.—On Wednesday evening, April 7th, members of the Napa County Medical Society and military colleagues from Mare Island and Hamilton Field were guests of the medical staff of the Napa State Hospital at Imola.

Dr. Karl M. Bowman, Director of the Langley Porter Clinic of the University of California Medical Center in San Francisco, spoke on "The Relationship of the Langley Porter Clinic to the General Practitioner." Dr. Joseph H. Catton gave an illuminating address on the subject, "Nerves and the Military." The discussion by members and physicians who are in active service with the Armed Forces was most interesting. A total of 68 physicians were present at the meeting.

Assemblyman Ernest Crowley made a brief speech, in which he emphasized the point that it is most desirable for members of the medical profession to contact the Legislators from their respective constituencies on prospective legislation pertaining to the public health and maintenance of medical standards so that members of the State Senate and the State Assembly will be in position to have a proper understanding of issues presented to them. C.M.A. officers who were present included President-Elect Karl L. Schaupp; Past-President Henry S. Rogers; Councilor John W. Green; Chairman of the Committee on Public Policy and Legislation, Dwight Murray; and Secretary-Editor, George H. Kress.

Vallejo Community Hospital.—City officials, architects, sponsors, contractors and others interested in the Vallejo Community Hospital, participated in the official ground breaking for the structure Monday, (4/5) and annnouncement was made that the structure would be completed, ready for use, in 180 days.

This 262-bed institution is being constructed by the Emergency Operations Unit of the Public Buildings Administration of the Federal Works Agency, and will provide adequate hospital facilities and service for the 100,000 people now resident in Vallejo. It is located to the right of the Napa Road, one mile north of Vallejo. It will have an emergency capacity for 300 to 350 beds.

Barrett and Hilp, general contractors, San Francisco, are the contractors for the $1,100,000 project, and Douglas Dacre Stone, San Francisco, is the architect. . . .

J. Hayden Perkins, commissioner of public health and safety, of Vallejo, led the campaign for the new hospital and was the chief sponsor for the new federal project.

In addition to the main group of connected buildings, containing 12 wards and 150,000 square feet of floor space, there will be two homes for the 100 nurses and two buildings to house the 40 other resident employes. . . .

Surrounding the buildings on the 20-acre plot, will be wide areas of lawn to prevent any dust blowing into the hospital. Roadways are beyond these grassed spaces except for the emergency entrance. These features are all standards of the U. S. Public Health Service.

Stone explains another construction method which helps reduce the per-bed cost of the completed hospital to approximately $5,000, a remarkably low figure. It is the use of the module system of measurement. One module is equivalent to four feet and all dimensions are given in modules. This unit of measurement fits almost every kind of material used with a minimum of waste and also speeds up the actual construction work.

"From the out-patient department to the x-ray rooms, the laboratories, pharmacy, dental department and all the wards, the hospital will be absolutely modern and up to the standard required by the U. S. Public Health Service," says Stone. "Every item of equipment is provided for, $200,000 of the contract price covering these facilities. When completed this national investment in the public's health will give Vallejo the best hospital that modern science knows how to build."

New Veneral Disease Isolation Unit in Los Angeles.—The Venereal Disease Control Divisions of the City and County Health Departments have for some time been active in promoting an isolation unit for genitoinfectious diseases at Los Angeles County General Hospital. Through Lanham Act funds it is expected the hospital will be enabled to set up this isolation unit. The ward, designated 10,800, is to open, subject to final approval of Washington, to receive females either strongly suspected of having, or known to be infected with syphilis or gonorrhea. The ward is a 40-bed unit and will be staffed and supplied by the hospital. Members of the City and County Health Departments are to be made members of the attending staff under the direction of Dr. Kendal Frost, Director of the Department of Dermatology. The expensive communicable disease technique, as formerly applied to in-patients with venereal diseases in the C. D. unit, will be modified to fit our present knowledge of the communicability of syphilis and gonorrhea. It is estimated that the modifications in technique will reduce the cost per patient day from $15 to $4.

The patients are to be held in the ward under quarantine until their infection of gonorrhea is cured or, in the case of syphilis, until such time as they are rendered noninfectious. The approximate maximum period of quarantine will be three months. Persons referred to this unit are to be mainly the reported contacts of infection in military personnel; however, civilian contacts who prove unresponsive to the usual follow-up procedures will be isolated as well. Also, clinic patients who have infectious gonorrhea or syphilis and who prove to be recalcitrant or who persist in acts which tend to spread their disease, will be quarantined. It is hoped that many of the persons will voluntarily accept quarantine in order to take advantage of hospitalization. There is absolutely no intention of making this ward a jail or punishment for having a venereal disease. Patients will enjoy such benefits of hospitalization as are compatible with their infection and will be prosecuted under law only if quarantine is broken. The rules and regulations of this quarantine are as established by law.

Accepted methods of treatment for venereal disease are to be used. It is also planned to offer patients infected with early syphilis the rapid scheme of therapy as proposed and documented by Dr. Harry Eagle of the U. S. Public Health Service. This treatment requires 8 to 10 weeks for completion and the usual 5 to 10 years of post-treatment observation. This isolation unit is a forward step in the control of syphilis and gonorrhea.

Nylon Suture Material.—Millions of feet of nylon monofilament that formerly went into tennis racquet strings and fishing leaders may replace silk this year in surgical sutures for the Army, Navy, civilians, and lend-lease shipments.

Surgeons use as small a suture as is consistent with the strength required, for the smaller the material the less the chance of irritation. Nylon has greater tensile strength than silk and can be produced in uniform diameters.

The synthetic is so inert and nonirritating that it can be used internally as well as externally. It does not fray or splinter. There is no chance of small slivers wearing off the suture and working through the body.

Examinations for Interns.—The Los Angeles County Civil Service Commission announces that applications for the position of Intern in the Los Angeles County Hospital will be accepted from Wednesday, February 17th, until Thursday, April 15th. There will be no written test. Candidates will be rated on their professional training and experience, and their aptitude and personal suitability for internship, as evidenced by investigation or interview.

All candidates must be citizens of the United States who have completed a medical course at an approved medical school in the United States or Canada, within five years prior to April 15, 1943, or who will have completed the course prior to July 1, 1944.

Application blanks may be secured from Deans of any of the accredited medical schools or full information may be obtained by writing directly to the Los Angeles County Civil Service Commission, Room 102, Hall of Records, Los Angeles, California.

International College of Surgeons to Meet in June.—The Fourth International Assembly of the International College of Surgeons will be held on June 14, 15 and 16, at the Waldorf Astoria Hotel, in New York City. Delegations made up of surgeons from the United Nations in addition to those from other countries are expected to attend.

American Board of Opthalmology.—Examinations will be held in New York City, June 4th and 5th, and in Chicago, October 8th and 9th. Candidates will be required to appear for examination on two successive days. For formal application blanks, write to Dr. John Green, Secretary, 6830 Waterman Avenue, St. Louis, Mo.

American Urological Association.—The $500 Research Prize annually offered by the American Urological Association will not be awarded this year. Under existing circumstances, plans for the June meeting of the American Urological Association in St. Louis have been cancelled.

Handbook of Diagnostic Instruments and Technique in Medicine.—A 72-page publication, illustrated, has been announced of a Handbook on the Reichert Collection, illustrative of the evolution and development of diagnostic instruments and techniques in medicine. The Collection itself is now on view as a loan exhibit at the Wellcome Exhibition Galleries (Burroughs Wellcome & Co.), in New York.

The Collection has been assembled by Philip Reichert, M. D., New York, for use as a reference laboratory by investigators interested in the field of methods and apparatus. It provides a careful map of the route along which our diagnostic armamentarium has come, and gives not only perspective for the present, but perhaps a clue as to the direction in which further development will be made.

The Handbook is designed primarily as a guide to the study of the objects in the Collection. The distribution of the Handbook is complimentary but will be limited to members of the medical and allied professions.

American College of Chest Physicians Cancels 1943 Meeting.—The following resolution was adopted by the Board of Regents of the American College of Chest Physicians:

Resolved, That the Board of Regents of the American College of Chest Physicians meeting in Executive Session in the City of Chicago, on the fourteenth day of February, in the year nineteen hundred and forty-three, hereby proposes that the 1943 annual session of the American College of Chest Physicians be cancelled.

It was recommended by the Board of Regents that wherever feasible, State and District Chapters of the College arrange to meet jointly with their State and District Medical Societies, and assist in preparing scientific programs concerning the specialty of diseases of the chest.

Civilian Defense: "War Emergency Radio Service."—The "War Emergency Radio Service, WERS," is a new system of two-way radio communication for use of Civilian Defense and other defense forces in local areas. It is rugged, home-grown, highly adaptable, and of the greatest use before, during, and after an air raid or other emergency.

WERS can be set up only by specific authorization of the Federal Communications Commission.

The FCC has assigned to WERS a number of frequencies, the more important being from 112 to 116 megacycles. Within this range OCD recommends that operation be planned for three bands of several channels each. At need there would be available 14 distinct channels so that there is no practical limit to the system's flexibility. . . .

The new emergency radio system is of direct use to many strategic centers and installations in the community, such as hospitals, industrial plants, railroad yards, docks, bridges, and public utilities. Its importance to these points appears in the two following representative cases.

1. *Industrial plants*—

2. *Hospitals.*—It is crucial to know during a raid exactly what beds are available and what operating rooms are free in the casualty receiving hospitals of a community, and to direct casualties rapidly to available facilities. If telephones go out, the control center can still keep a complete picture of the hospital situation by WERS. By use of the new system, ambulances can be loaded and disptached effectively because the control center is in communication both with hospitals and with the incident officers and incident medical officers. Mobile medical teams can be directed from point to point without returning to their bases. If the hospital facilities of an area become overtaxed, the radio channel to the district headquarters can arrange for reinforcing hospital facilities. For hospitals, WERS represents a communica-

tion asset whose value is written in terms of saved lives.

Thousands of volunteers are helping set up the new WERS system. Amateurs otherwise banned from the air are today helping to build and operate thousands of two-way stations needed throughout the country. In community and nationwide drives, attics and back rooms of radio repair shops are ransacked for junked sets and unused material—it is the existence of this material which puts the United States out in front as the country most ready for the rapid setting up of this fool-proof communications auxiliary. With the materials gathered, volunteer groups construct stations which become the property of the defense forces. Not only amateurs, but qualified repairmen, electrical trade unionists, and persons holding commercial radio operators' licenses, including radio engineers employed in broadcast stations, are joining in this work.

All the defense personnel who will operate the newly constructed stations must be trained, and each one specifically who will operate a station must obtain a permit from the FCC. This permit is not hard to get—after training, it means the passing of an elementary FCC test. Many Defense Councils have organized classes in WERS operation.

For further information on this subject, communicate with the Editorial Section, Office of Civilian Defense, Washington, D. C.

Dr. George Dock, Medical Dean, Still Student at 82.—Medical students used to relate a story about their favorite professor, Dr. George Dock.

"Ask any other teacher what time it was," they would say, "and he would pull out his watch and tell you.

"Ask Dock and he would pause, reflect a moment and finally mutter, 'That's an interesting subject. Let's look into it.'"

Dr. Dock's passion for inquiry and research has followed him through all the years.

Still a Student

Today, at 82, as dean of the medical profession in the Los Angeles area, he is still a student, engaged in studies designed to broaden medical knowledge.

A former associate of the great Osler, Dr. Dock, a practicing physician for 59 years, has made many contributions to his field.

He is proudest of his former students who have risen to eminence, seeing in their accomplishments an extension of his own aim—greater knowledge through research.

Author of Textbooks

His book, "Outlines for Case-Taking," is a standard text at most of the nation's medical schools. One of the first books published on hookworm disease came from his pen. He also edited a volume on the heart.

The years have not dulled the edges of the physician's mental processes. Associates say his mind is as keen as a scalpel. He has deep-socketed, appraising eyes that seem, at a glance, to make a complete diagnosis.

When he makes the usual amenity of asking, "How are you?" to a friend you feel he knows the exact answer even before the question is put.

Birthday Observed

Dr. Dock is the only physician whose birthday, April 1, is observed by the Los Angeles County Medical Association. A lectureship, sponsored by the Barlow Society for the Study of the History of Medicine, also is named after him.

In addition to his discoveries, Dr. Dock has made other contributions better known to the public at large. He is responsible for hospital beds being at their present height, a change he initiated more than 30 years ago when he observed how cots at a lower level tired attendants caring for patients.

He also instituted the first general use of white coats among hospital attendants, making use, at the start back in the '90's, of butchers' outfits.

Dr. Dock, who has offices in Pasadena, believes medicine is still in its infancy as far as research is concerned, pointing out that more knowledge has been gained in the last 50 years than in all the time before.

"The future," he says, "is an endless vista."—Los Angeles *Times*, February 21.

International College of Surgeons.—The coming fourth International Assembly of the International College of Surgeons will be held at the Waldorf Astoria Hotel in New York City, on June 14, 15, 16, dealing with the subjects of "Rehabilitation" and "War Surgery."

Visitors to the Assembly are urged to view the many exhibits which will be set up to demonstrate activities in military medical affairs and rehabilitation. . . . The Veterans Administration, Washington, D. C., of which Charles M. Griffith is Medical Director, will furnish charts showing pictures and descriptions of the routine and special measures in occupational therapy, and physical therapy used to aid in the treatment of patients in Veterans Administration Hospitals.

Autopsy Surgeon Examination.—A salary of $4800 a year is being offered by the Los Angeles County Civil Service Commission, to the doctor who is selected for the position of Autopsy Surgeon, M. D., for work in the Los Angeles County Department of Coroner.

There will be no written examination for this position as candidates will be rated on their professional training and experience and their ability and personal suitability for the work, as evidenced by investigation or interview.

Doctors, in age 21 to 55, with an M. D. degree from an approved medical school, who have completed at least one year's internship in an approved hospital and who have had two years of professional experience in the pathology laboratory of an accredited hospital, medical school, or commercial laboratory or in a public agency, may file an application for the permanent Civil Service position. Those over 55 years of age may file for "duration" work.

Full information may be obtained from the office of the Commission, Room 102, Hall of Records, in Los Angeles, California. Applications must be filed on or before Monday, May 24, 1943.

Doctors of Medicine as Others See Them.—During recent years, the medical profession and its work have been much misrepresented in certain lay publications. A perusal of editorial comments appearing in some California newspapers, in which appreciation is expressed for the healing and altruistic work of physicians, should therefore be of interest.

The above item, with some quotations appeared in California and Western Medicine (July issue, pages 108-109; October, pp. 269-270; November, pp. 287 and 331-332; January, pp. 49 and 50; February, pp. 92-93, and April, pp. 225-257. More recent excerpts follow:

Free Choice Means Progress

A basic principle of democracy is free choice.

Significantly, extremists who urge adoption of broad compulsory health programs give scant attention to the basic principle.

Free choice guides every act in our daily lives. We can go to the church we choose, we can buy groceries from whom we please, we can choose the car in which we ride, we can say what we choose, we can choose the schools we wish to attend.

Whenever we abandon the principle of free choice, we hurt no one but ourselves. And that goes for medical service. Free choice of a doctor automatically encourages medical competence. The most qualified are the most patronized. As a result, every doctor is spurred on to achieve the reputation of being a good doctor.

This incentive, or whatever you wish to call it, is the background of every doctor's training. It embodies more than mere financial success.

Pride of accomplishment, the heart-warming feeling that people come to him because they believe in him, these are part of the incentive inspired by free choice which governs the career of the average doctor.

The same inspiration has been responsible for the miraculous scientific discoveries that have come from research laboratories of American medicine.

If we abandon the principle of free choice in the field of medicine, medical service will decline.—Isleton *Delta News,* March 5.

* * *

They See Alike

The medical profession is not opposed to health programs that do not embody ultimate elimination of private medical practice. The doctors are no different than representatives of industry, agriculture or labor, who oppose plans that would place government in control of the economic affairs of the individual. They are alike in their conviction that a people cannot lean on a government too heavily and still retain freedom.

For example, government-subsidized coöperatives can give the consumer goods "at cost." Temporarily the consumer appears to benefit. Actually, he loses, because his neighbor is inevitably forced out of business—the stimulant of competition disappears, quality drops, and economic independence gives way to utter dependence on a monopolistic provider, government.

And so it is with medical service. The doctors know that present high standards cannot be maintained except under a system of private medicine. They gladly contribute much free time so that no one need suffer for lack of proper medical attention. During the war emergency, they are working night and day to preserve the nation's health. But they oppose health plans that would make the government the prime dispenser of medical care.—San Juan Capistrano *Coastline Dispatch,* April 2.

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From the Cradle to the Grave

President Roosevelt's "blueprint for peace," is too all-inclusive, too complicated, too far reaching for anybody but the seventh son of a Philadelphia lawyer to understand right offhand.

However, it does create the impression that the administration desires to remake the United States into a sweet land of never-worry, a Utopia where good old Uncle Sam will make all your decisions, guide your life, provide for your care when ill and support you when you quit your job or get old.

Silence of the new deal dreamers in the recent past probably can be explained now. They have been working out this super-new deal which would give the government increased power over the individual from the cradle to the grave.

It's a pretty picture—full employment for all employables, jobs guaranteed for the soldiers and war workers when peace comes, and security, adequate housing and health protection for all.

On the other side of the picture we will have a greatly increased power over your life centralized in the federal government, taxes that will total many billions a year, payroll assessments and income limitations exceeding those now in effect and restrictions on individual freedom and decision. The government will look out for us, but make us pay for the service.

The old American ideals of thrift, the pioneer spirit to prepare in active years for the declining years of life are *out.* You can give from day to day without worry, for Uncle Sam will take care of you.

The government proposes to maintain a "partnership" with certain large corporate enterprises, while the super-new deal assessments and restrictions will probably compel many small businesses to shut up shop.

The definition of state socialism varies, but we can't help but wonder what the difference might be, in a general sort of way, between these proposals and some of the super-governments in Europe. The perfectly planned economy, with an all-powerful government guiding the life of every citizen, look fine on paper, but it seems a revolutionary departure from the American way of life as we knew it in the years gone by.—Red Bluff *News,* March 11.

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Rationed Doctors

The military services have had to take so many doctors that, from now on increasingly, medical services must be "rationed" for the duration. This does not mean that we should pass up necessary medication or surgery. It does mean that those with money should give up luxury service, in order that the available doctors and nurses may care for cases of real need.

In many communities there are serious shortages, arising sometimes from departure of too many doctors or from the mushrooming of cities and towns so that they have outgrown medical facilities.

Coöperation will help meet this crisis, like others.—Chico *Enterprise,* March 11.

* * *

Keep Healthy For Victory

Doctors, Nurses, Hospitals Are Coöperating; Public Called Upon to Help

Health is becoming, increasingly, a personal responsibility and a patriotic duty. With one-third of the nation's doctors already in uniform, civilian health and working power may be threatened unless remedial steps are taken soon.

These steps should be directed toward proper distribution of doctors remaining in civilian practice, according to special abilities.

Meanwhile, if American standards of health are to be maintained, on a voluntary basis, it is the job of every citizen to protect his own health. This is a minimum contribution to America's strength.

The medical profession is giving its voluntary coöperation toward distributing doctor-power as widely and effectively as possible.

Working All the Time

"Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health," a government survey pointed out.

This is true of many physicians in San Francisco, despite the fact that this city has a relatively large number of doctors serving the civilian population compared with many other communities.

San Francisco physicians are helping the California Procurement and Assignment Service to locate doctors in nearby crowded war-industry areas where boom-town conditions prevail and the doctor shortage is critical.

Leaders of the local medical profession have issued strong recommendations to all local doctors on conservation of doctor-power, nurse-power and hospital space.

Group Nursing Plan

Group nursing allows one special nurse to care for two patients in cases of the type permitting a nurse to divide her time equally between them.

Organized nursing in San Francisco has likewise taken steps toward spreading care of hospital patients as widely as possible. The San Francisco County Nurses' Association has pledged that its private duty nurses will take general duty on a hospital staff at least one month out of each year, and the Association's Nurses' Registry is placing as many private duty nurses as possible on staff duty.

Retired nurses are being urged to return to active service.

Thus all who are concerned, professionally, with the protection of civilian health are doing their utmost to keep San Franciscans fit for the great tasks they are performing and the greater ones which they may soon be called upon to perform.—*Editorial* in San Francisco *Call-Bulletin*, April 26.

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Doctor Shortage

On the basis of OWI's figures, the United States has 150,000 physicians to serve 135,000,000 people. One-third of these have joined the armed forces, where they are serving say seven million and a half men or about one-twentieth of the population. Of course, the armed services need more doctors in proportion to their numbers.

"The men in uniform," says OWI, have been and will continue to be the best cared for medically in the world." We want it this way. But this does not alter the fact, also reported by OWI, that the remaining two-thirds of the physicians are not enough for the 127,500,000 civilians. The soldiers and sailors, conveniently assembled, have a doctor to every 150 men. The civilians, in many cases badly scattered, have a doctor to every 1,275 men, women and children. Nor are the doctors distributed among the civilian population on this average. There are communities with 4,000 to one doctor, some smaller communities in reach of no physician.

This condition will grow worse as the armed forces increase. And this civilian population is the base and support of the armed services. Its health is essential to maintaining the Army and Navy. OWI, which has made a survey, says as yet there is no serious impairment of the health of the nation, "but unless we initiate some method of appraising the problem and deciding on the best plan to meet it, interference with mass production due to widespread sickness can be expected."

OWI makes no bones of laying some of the blame on recruitment of doctors for the armed services "without sufficient regard for the welfare of the civilian population." There is ground for thinking this is not the only case in which Army and Navy have ignored the needs of their civilian base. Some of the food shortages are apparently due to military buying and storage regardless.

The Army and Navy are not to be criticized on these points. They are obliged to go as far as they can. The blame lies on the Government for not maintaining a proper balance between military takings and civilian needs vital to military success. Nor is the government to be excused for not taking positive steps to redress the doctor situation. OWI says there are still enough physicians in private practice to control the health matter if they can be properly distributed. But nothing much has been done.—San Francisco *Chronicle*, March 30.

* * *

Inexcusable

Attempts to create fear that civilian medical service is on the verge of a breakdown, as a basis for advocacy of pet social theories in the field of medicine, are a grave threat to national morale and public health. This is the view of many eminent medical authorities, and is doubtlessly shared by millions of persons who are fed up with attacks on the doctors. The doctors have been doing a good job under difficult circumstances. By their ceaseless effort this has become the healthiest nation on earth. And now, when many of them are serving in the armed forces, is decidedly not the time to permit adoption of "Pearl Harbor" sneak measures that would result in the medical profession being put under the jurisdiction of some kind of a "czar."

An editorial in *Hygeia* says: ". . . The American medical profession began to plan in June, 1940, for the emergency. Doctors are being rationed even more scientifically than are gasoline, fuel and tires; far more scientifically than are the members of other professions and trades. The procurement and assignment service for physicians, dentists and veterinarians, merits the confidence and help of industrial leaders, public health and social service workers in allocating physicians to areas where there are apparent shortages."

Playing politics with public health is inexcusable.—Lincoln *News-Messenger*, February 25.

* * *

Living Up to Tradition

The medical profession hasn't done a lot of talking about the "sacrifices" its members are making. And yet doctors, perhaps more than any other group next to the service men, are making real sacrifices in this war.

Thousands of them have voluntarily given up their practices. They live in the foxholes with the soldiers. They fight and die with the Navy and the Marines. They perform miracles amid blood and suffering. Gone is the business for which they spent so many years in preparation, often on a financial shoestring.

The doctors left at home are making sacrifices, too. Men who should be enjoying the leisurely aftermath of useful careers are back in harness working at a killing pace. They are on duty 24 hours a day—and they don't yell for time-and-a-half when Mrs. Jones is having a baby at 3 a. m.

The doctors are carrying out the tradition of American medicine in every emergency. Their example might well be followed by workers in other fields.—San Francisco *Organized Labor*, February 20.

* * *

Our Neighbors' Health

Few people realize how medical progress, such as has been made in the United States during the past generation, is being extended to the other American countries. Not only in commerce, but in health must North and South America be closely allied.

The publications of the Pan-American Union and the Pan-American Sanitary Bureau indicate that certain problems of the South American nations, which may be as much scientific as economic, demand the aid of their North American neighbors for ultimate solution.

Good health is fundamental to human progress. The downfall of many a nation may be definitely related to

malaria, plague, cholera or smallpox. Fortunately, the United States has been able to stamp out most of the great plagues which beset the rest of the world. Through philanthropic and other agencies it is giving its help wherever possible to aid other nations in meeting these hazards.

If we can help bring to other countries some of the blessings that have fallen to this nation as the result of a tireless, independent, self-sacrificing medical profession, we will be greatly benefiting ourselves. To illustrate, plague that is prevalent in Java, India and China, has been detected among rodents in the far west of the United States. It was carried here years ago on ships from the Far East. The mosquito that carries yellow fever has been found in airplanes flying into the United States from other countries.

A progressive and watchful medical profession, and the constant interchange of information from the health officials of all the Americas, is necessary for the salvation of all the American people.—Reedley *Exponent*, March 18.

* * *

'Deterioration' in U. S. Health Feared

Washington.—The Office of War Information today disclosed the probability of a "slow deterioration" in the nation's health because of an acute lack of doctors in many communities.

"There is not at present a serious breakdown in health," the OWI said, "but unless we initiate some method of appraising the problem and deciding on the best plan to meet it, interference with war production due to widespread sickness can be expected."

Approximately one-third of the doctors in the United States—between 40,000 and 50,000—have joined the armed forces, the OWI said, and as the size of the Army and Navy increases more will be called.

"The men in uniform have been and will continue to be the best cared for medically in the world," it added.

But the problem of civilian health is increasing and in total war the health and working power of the civilian is as important as health and striking power of the man in the battle line. To offset lack of medical attention, attempts are being made to apportion the available supply of doctors as equitably as possible.

The OWI recently surveyed some 60 communities and 20 states where shortages of doctors have been reported. These conclusions were reached:

1. So far the health of the nation as a whole has not been seriously impaired by the doctor shortage. Doctors these days are not only working overtime; they are—most of them—working practically all the time and in total disregard of their own health.

2. The number of communities critically in need of doctors is not great compared with the total number, but those in need are among those most vital to the war effort.

3. In too many cases doctors were recruited for the armed services without sufficient regard for the welfare of the civilian population; enough remain in private practice to give adequate civilian care "provided they can be properly distributed numerically and according to special abilities."

4. The voluntary relocation of doctors has not resulted in a solution of the problem. In some communities local medical groups have resisted attempts to relocate outside doctors in their locality.

5. The situation as a whole is not now out of control, but unless remedial steps are taken soon it will grow progressively worse.

6. Luxury medicine is out for the duration. "We can no longer afford to call doctors for imaginary ailments."

The survey emphasized that medical shortages are not due in all cases to the war. For example, many rural areas have never had a sufficient number of doctors. In other regions, where the population has in many cases doubled and trebled due to war industry, conditions have not improved. The OWI found sections where there was only one doctor to 5,000 to 6,000 persons, with the people frankly worried over what might happen if any number of them became ill at the same time.

In a county on the West Coast, near a Navy yard, the survey reports an increase in population from 44,000 to 110,000, and during 1943 it is expected that 25,000 more persons will move into this area. The present ratio is one doctor to 4,000 persons, and the hospital situation is described as "terrible."—San Francisco *News*, March 29.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Irwin Center Sends Plasma to Services

The Irwin Memorial Blood Bank of the San Francisco County Medical Society supplied 565 units of whole blood to Bay Area hospitals during March, Dr. Curtis E. Smith, chairman of the Society's Blood Bank Commission, announced yesterday.

Increased donations are needed, he said, to supply local needs and the various services. There were 1052 donors during the month, but more are needed.

Dr. Smith announced that 859 units of frozen plasma is maintained in San Francisco hospitals for use in an emergency and that although 18,000 persons have given blood since the bank was opened in June, 1941, more donations are needed because of increased demands.

"What the Red Cross is doing on the fighting fronts, the Irwin Blood Bank is doing on the home front," said Dr. Smith.

"Bank your blood while you can; you may some day need it yourself," is the slogan of the Irwin Bank, which is located at 2180 Washington Street.—San Francisco *Chronicle*, April 25.

S. F. Doctor New Head of Industrial Surgeons

Dr. C. A. Walker of San Francisco, Chief Surgeon of the Southern Pacific, yesterday was elected president of the Western Association of Industrial Physicians and Surgeons at its third annual convention in the Biltmore Hotel.

Dr. Walker succeeds Dr. Benjamin J. Frees of Los Angeles, who was elected to the board of directors.

Dr. Rutherford T. Johnstone of Los Angeles was reelected secretary and Dr. J. M. McCullough of Crockett was reëlected treasurer.

Dr. Richard Scofield was elected to the board of directors, to which Doctors Robert T. Legge of the Berkeley campus of the University of California and John D. Ball of Santa Ana were reëlected.—San Francisco *Examiner*, April 30.

Labor-Management Unity Needful for Industrial Medical Service

New York (FP.)—Coöperation of labor, management and the community is needed to end absenteeism from illness and accidents which, conservative estimates show, cost 500,000,000 man-days in American production during 1942.

In spite of the great need for coördinated health services and medical care, labor, management, and other community interests are attacking the problem separately. Old barriers keeping labor, management and medicine from discussing health care for workers must be torn down—at least for the duration.

There has been so much muddling in the handling of medical manpower that a nationwide shortage of physicians in industry and civilian life is threatened. In many sections this shortage already exists. . . .

California Shows Way

Some things have been accomplished. In California, the Federal Public Housing Authority and the California Physicians' Service arranged a plan of health centers in housing projects for defense workers. Payments to the plan are collected with each month's rent.

Unfortunately, management is not yet completely in the picture. All sections of the community must pull together on the health front, because the whole community

is at war. The health of any section should be of vital concern to all other sections. . . .

There is another important reason for labor to increase its interst in health and medical care problems now. In any American Beveridge plan, provisions for health and medical care will occupy an important place. Good medical care will no longer be a luxury. Medicine will be made democratic, but only if labor works to make it so.—San Diego *Labor Leader.*

Talk on Nursery Plan Heard by Social Workers

More than 200 social workers representing Federal, State and municipal agencies met at the State Building yesterday for detailed instructions on the application of the Lanham Act, under which Federal funds are being allocated for the care of children of war-working mothers.

The meeting was conducted by Mrs. Florence Kerr of Washington, D. C., assistant administrator of the War Public Services, an office under the Federal Works Agency. She was assisted by Mrs. Mary H. Isham of Salt Lake City, western regional director; Frank G. Morrison, in charge of the nursery school program in this area, and Wallace Campbell, regional finance examiner, of the same organization.

Fund Appropriated

The social workers were told that approximately $75,000,000 has been allocated for the establishment of nursery schools for children from 2 to 5 years of age and for recreational activities for children of school age throughout the nation. In California, Mrs. Kerr said, the State and other agencies are expected to contribute one-half the operational costs of the program.

Thus far only two schools using Lanham Act money are in operation in California, one in Bellflower and the other in Vallejo.—Los Angeles *Times.*

War Meal Danger Told

You may be getting by now, but if you don't watch your step during this wartime, you may be laying the basis for digestive disorders later on.

That word of warning was brought here yesterday by Dr. George H. Kress, of San Francisco, California Medical Association secretary, who arrived at the Biltmore to make arrangements for the Association's convention, May 2 and 3.

Reporting nutritive deficiency diseases will occupy a prominent place in the convention program, Dr. Kress declared:

"Due to the extensive war work in Los Angeles, including night shifts and irregular hours, this area may be particularly subject to such diseases because of irregularly spaced meals."—Los Angeles *Examiner,* April 13.

Medical Insurance Plan

New York, April 5.—(AP.)—Mayor F. H. La Guardia announced today that he has drafted a citywide medical service insurance plan and would appoint a committee this week to work out the details.—San Francisco *Call-Bulletin,* April 6.

Public Aid to the Needy

Years of WPA Cost Less Than Months of War

Washington, April 25.—(AP.)—Relief in the form of doles or payments for work on public projects cost the American taxpayer nearly $25,000,000,000 during the 1933-42 decade.

That sum, including money spent by federal, state and local governments, exceeds the entire national debt through 1933, but is less than a third of what the federal government alone will spend in the wartime fiscal year ending June 30.

Costs Not Included

Shown in data compiled by the Social Security Board, the sum covers "payments to recipients of public assistance and earnings of persons employed under Federal work programs in the continental United States, January, 1933-December, 1942." It does not take into account money spent for administrative purposes or for purchase of materials.

Biggest single item in the $24,829,692,000 outlay was $9,042,928,000 in Federal funds paid those on the rolls of the Works Project Administration.

The second greatest single item was $6,055,431,000 credited by the Security Board to "general assistance," provided exclusively by state and local governments without matching federal funds.

Third was $3,024,251,000 expended on old age pensions, with the federal and state governments sharing the cost, and fourth, $2,139,008,000 to enrollees of the Civilian Conservation Corps.

The Blind Helped

Other expenditures in the ten-year span were given as follows:

Aid to dependent children, $900,306,000; aid to the blind, $158,976,000; federal emergency relief administration (predecessor to the WPA), $186,158,000; Farm Security Administration, $137,268,000; National Youth Administration, $508,492,000; Civil Works Program (also a WPA forerunner) $718,016, and projects operated by various Federal agencies on emergency funds, $1,958,858,000.—San Francisco *Chronicle.*

Health and Socialism

Northwestern University has just published a report, based on an exhaustive study made by members of its staff, of compulsory health insurance in the United States. The report should be read by every American citizen. It warns of dangers inherent in social schemes that envisage government as the sole dispenser of medical care at the expense of the general taxpayer. It stresses the need for treading cautiously lest in a hasty grab for Utopia, social and economic progress be lost and medical standards irretrievably lowered.

In its practical application, compulsory health insurance reverses the normal doctor-patient relationship. At present the patient is anxious to get well and get back to work. The doctor, too, is anxious to secure quick recovery for his patient. He knows that big doctor bills and lengthy illness do not contribute favorably to his reputation in the patient's mind. Under compulsory health insurance, the patient is paid by the government (taxpayers) for being sick. The longer the sickness, the more he receives. A "good" doctor is liberal in certifying clients as eligible to receive cash benefits. On the other hand, an ethical doctor often arouses the antagonism of clients by refusing unjustified benefits. Under the pressure of "free money" the integrity of patient and doctor deteriorates. This is a fact borne out by experience in nations having compulsory health insurance.

Aside from a tendency to lower medical standards, compulsory health insurance, if adopted, would be one more move toward socialism. Its advocates openly admit that it is but a short step from there to total government domination of medicine. Socialized medicine would result in a vast expansion of bureaucracy, and human nature being as it is, the doctors themselves would be forced to become politicians as a requisite of success. No longer would medical skill be the sole criterion of advancement.—Merced *Sun-Star,* April 10.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Legal Restraints on Contraception

A recent decision of the United States Supreme Court, *Tileston v. Ullman,* 87 L. Ed. Advance Opinions 443, calls attention to the fact that there are still some states in the Union where it is unlawful for a person to use contraceptives and equally unlawful for a physician or surgeon to prescribe or advise as to their use by even a married woman. The constitutionality of a law of the State of Connecticut forbidding "the use by any person of any drug, medicinal article or instrument for the purposes of preventing con-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from the syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

ception" and making liable to prosecution any person who "shall assist, abet or counsel another to commit such an offense" was questioned in the case of *Tileston v. Ullman*, 129 Conn. 84, 26 Atl. (2d) 582, decided May 22, 1942, by the Connecticut court and an appeal was taken to the Supreme Court of the United States from the decision upholding the validity of the statute.

The plaintiff in the case, a licensed physician, brought an action in the state court for a judgment interpreting the above statute and declaring it unconstitutional if it should be construed to make it unlawful for him to prescribe the use of contraceptive devices for married women living with their husbands who came to him as patients in cases in which his professional judgment dictated that such treatment be given in order to preserve the life or health of the woman patient. Three cases were specified by the physician, in each of which the patient suffered from some physical disability, such as high blood pressure, tuberculosis or a generally weakened condition as a result of previous pregnancies, which would be seriously and dangerously affected by the patient becoming pregnant. The plaintiff physician requested the state court to imply an exception in the stated law to allow the prescription of contraceptives in those cases where it was necessary to preserve the life or health of the patient and in support of this construction of the law advanced the theory that if the law were not so interpreted the Connecticut statute should be held unconstitutional as unreasonable and violative of the due process of law clause of the Fourteenth Amendment. In a previous case, the court had refused to construe the section in question as allowing a duly licensed physician to prescribe the use of contraceptives where "the general health and well being of the patient require it." In the instant case, the court was asked, however, to adopt a construction of the statute which would permit the prescription and use of contraceptives in cases where not only the general health of the patient was involved but also there was imminent danger of loss of life, the need for such action being more obvious in such cases.

The Connecticut statute was adopted originally in 1879 and the court recognized that during the intervening period a considerable change had taken place in the views of a great number of people on the subject. Notwithstanding this change in social outlook, the court refused to read any such exception into the statute and clearly held that even in cases where the life or health of a patient might be seriously endangered, a Connecticut physician would be subject to criminal prosecution for advising such a patient in the use of any means to prevent conception and the resulting pregnancy.

The plaintiff physician had argued that such a construction of the statute would be violative of the due process of law clause because it would be unreasonable to forbid the prescription of contraceptives in cases where professional opinion was unanimous to the effect that the safest medical treatment which could be prescribed for a given patient would be to advise of proper methods of preventing conception which can be used safely and effectively and thus to avert the unfortunate consequences which might flow from pregnancy. It was pointed out, however, that there was another remedy of certain result and that was to advise complete abstinence. The court said that the reasonableness of this latter course was a question for the legislature and until such time as the legislature chose to act by amending the law the court could not sanction conduct in direct conflict with the words of the statute.

On appeal to the United States Supreme Court in *Tileston v. Ullman*, 87 Law Ed. No. 8, p. 443, it was held on February 1, 1943, that the plaintiff physician had no standing in court to question the constitutionality of the statute because the sole constitutional attack under the Fourteenth Amendment had been confined to an allegation that the law as interpreted might deprive the patients of their lives. Since the patients were not parties to the action, the court ruled that the physician had no standing in court to secure an adjudication "of his patients' constitutional right to life, which they do not assert in their own behalf."

In view of this ruling unfortunately the court did not consider it necessary to pass upon the general validity of the Connecticut statute. Consequently, it is still law in Connecticut that even though a woman patient's life would be seriously endangered by pregnancy, a physician is not allowed to prescribe or advise her in the use of contraceptives.

LETTERS†

Concerning San Francisco Chapter of Pan American Medical Association:

PAN AMERICAN MEDICAL ASSOCIATION
San Francisco, March 29, 1943.

At a recent business meeting of the Association, the following officers were elected: President, Harry Alderson; Vice-President, John P. Strickler; Treasurer, Edmund Butler; Secretary, Salvatore Lucia. Regional Administrators of California: S. H. Babington, Berkeley; Junius B. Harris, Sacramento; Charles P. Mathé, San Francisco; Albert Soiland, Los Angeles; and Francis Scott Smyth, San Francisco.

Last fall, a joint reception was held at the Bohemian Club in honor of Dr. Braun-Menendez, by members of our Association and the Herzstein Committee of the University of California and Stanford University Medical Schools. Doctor Braun-Menendez is a famous physiologist from Argentina, whose researches on renal hypertension have achieved world-wide recognition.

The annual dinner meeting of the Association was held at the Bohemian Club on January 9, 1943, honoring

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

the consular representatives of Latin America and visiting Latin American physicians and students. The Association received a great tribute in the fact that all the Latin American consuls were present, excepting two, who could not attend on account of illness. Many Latin American physicians were in attendance. . . .

Dr. Francis Scott Smyth, Dean of the University of California Medical School, gave a most instructive and interesting address on "Inter-American Medical Relations." Sr. Juan José Martinez Lacayo, Dean of the Latin American Consular Corps, spoke in Spanish on the wholehearted collaboration of the Latin American consuls with the officers of the Pan American Medical Association. The Honorable Annibal de Saboia Lima, Consul General of Brazil, expressed the appreciation of his country for the assistance of American physicians in combating infectious diseases in Brazil. The Honorable Sr. Fernando Berckemeyer, Consul General of Peru, and the Honorable Martín Luis Drago, Consul General of Argentina, voiced their recognition of the catholic work that the members of the medical profession are doing towards alleviation of human suffering in the western hemisphere.

Dr. Joseph Jordan Eller, Director General of the Association, has informed us that the Eighth Congress of the Association will be held at the Hotel Waldorf-Astoria in New York in September. The Congress will be devoted entirely to war medical problems with the idea of consolidating our medical efforts on a hemispheral basis. All branches of medicine and surgery will be represented and the most representative physicians from South America and Central America, as well as North America, will be present. The Congress will devote one or two days to the problems of the physicians in the Armed Services. Such subjects as: contagious diseases, treatment of burns, blood banks, sulfa drug therapy, traumatic and plastic surgery, together with dental problems, will be included in the program.

The chapter has 120 active members residing in central California. Of these, fourteen are in active service in the armed forces of our country. . . .

Salvatore P. Lucia, M. D., *Secretary.*

Concerning Medical Supplies to Soviet Russia:

(copy)

Russian War Relief, Inc.

Registered with President's War Relief Control Board No. 547

San Francisco, April 28, 1943.

To the Editor:—Through Russian War Relief there is now being organized in every State of the Union a specific and concrete method for the attainment of that unity and understanding between our Allies which is a prerequisite for victory.

Americans, through our organization, have sent invaluable aid to the fighting forces and the people of the Soviet Union. Over 70 per cent of this aid has been in the form of medical supplies. Now, as part of a tribute to Russia Celebration during May and June, we are asking for five million or more Americans to write a personal letter to a Soviet citizen. This plan was suggested by receipt in headquarters and by our contributors receiving hundreds of letters from Soviet citizens who have received clothing, food, medicines and other supplies contributed by Americans. These letters thanked the contributors, then in almost every case said: "I wish you would write to me."

Will you help in this National effort by publishing this letter in your Journal? It is an invitation to every doctor to send a letter to Russian War Relief, 422 Sutter Street, San Francisco. Each letter will be given to a doctor in Russia and will be translated by committees, teachers or a friend.

Yours very truly,
Phillips Davies, *Chairman,*
Tribute to Russia Celebration
For Northern California Division.

422 Sutter Street.

Concerning a Fake Solicitor (Health and Accident Policies):

(copy)

Visalia, California, April 12, 1943.

To the Editor:—A man by the name of C. A. Kelley is soliciting the doctors with what he claims is a noncancellable health and accident policy issued by the Income Guaranty Co., of South Bend, Indiana. The reason I write you is that he claims the company to be a subsidiary of Medical Protective of Fort Wayne, Indiana. He was so glib that I became suspicious and wrote Medical Protective.

I am advised that there is no connection whatsoever between the companies and that this individual has done this before. I thought it might be wise to report this to you so that it might be given publicity in California and Western Medicine to protect others who might be tempted to buy.

Margaret joins me in sending best wishes.

Sincerely yours,
George F. Keiper.

Concerning Physicians' Gasoline Allowance:

Following are excerpts from a letter addressed to the San Francisco County Medical Society by Legal Counsel Hartley F. Peart:

"We have received several inquiries from members of the Society as to what use they may make of additional gasoline allowed by their 'C' ration books.

"Under the regulations issued by the OPA, the preferred mileage allowed to physicians is limited to that necessary in making professional calls upon patients and the physician is not even permitted to use gasoline allowed by his 'C' book to attend medical conventions or meetings of the profession.

"In this connection, you may wish to call the attention of the members of the Society to the following requirements of the applicable regulations:

" 'Travel by physician between home and office. Although a physician is not entitled to preferred mileage for travel between his home and office merely to keep office hours and to treat patients, he may be allowed preferred mileage for professional calls even though travel on such calls require occasional visits to his office to pick up equipment or to obtain directions and information necessary to make such calls.

" 'Travel by physicians, surgeons, etc., for conferences, conventions or courses of study. Travel to or from conferences or conventions or in attending courses of study may not be included in preferred mileage, even though such activities may better equip such persons to carry on their professional work.

" 'Travel by supervisors and agency heads. Mileage driven by supervisors and agency heads who direct the work of physicians and surgeons may not be allowed as preferred mileage since such travel is not for making necessary professional calls, nor is it travel between offices maintained by them.' "

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 5, May, 1918

EXCERPTS FROM EDITORIAL NOTES

The Del Monte Meeting.—Reports of the annual meeting of the California State Medical Society will appear in the June issue of the JOURNAL. Suffice it to say that the meeting was one of the best from every standpoint that has yet been held. Many matters of vital importance came up for decision and the results will be far-reaching. Weather, location, and the spirit of the times combined to lend special distinction to its deliberations. . . .

Continuing Need for Surgeons in Medical Reserve Corps of Army.—California with a medical population of 5,687 has given 783 to the Army. This is 13.8 per cent, whereas our real quota should have been nearer 20 per cent. Not only is this number, then, somewhat below what it should have been, but it leaves the state rather low in the list of states in regard to this matter. California and Connecticut have each 13.8 per cent of its medical population in the Army, and so are contestants for the twenty-ninth position. Nevada still ranks first with 154 medical men in the state and 37 in the Army, which is 24 per cent of its medical population. Arizona is second, Montana third, and Pennsylvania fourth in the list of percentages. . . .

There will be added to the Army this year about three-quarters of a million men. These will require about 7,500 surgeons. The Council of National Defense at the present time is asking California for at least 200 more surgeons, but looking this matter squarely in the face it would seem as if 400 or even 500 would be more appropriate. . . .

Report of Provost Marshal General on First Draft.—Under date of December 20, 1917, the Provost Marshal General has issued a report of the results of the first draft for the Army under the Selective Service Law. The report is compendious and will afford material for much interesting study. On June 5, 1917, there were enrolled a total of 9,586,508 men, of whom 3,082,949 were examined. Of this latter figure 1,057,363 were certified for military service. Of those so certified, 252,294 failed to appear when called for examination and according to the law were accordingly certified for service. This leaves, excluding also certain other minor classes, a total of 2,510,706 men who were actually examined by local boards. Of these, 730,756, or 29.11 per cent were rejected for physical incapacity. Of these, 22,989, or 5.8 per cent, were rejected after being sent to cantonments by the local examining boards. Of the California men, 26.17 per cent were disqualified for physical reasons.

Practically one-half of those called claimed exemption on some ground and of these 39 per cent were exempted, constituting 77.86 per cent of the total claims made for exemption. Less than 6,000 arrests were made for failure to register.

The total expense of the draft was $5,211,965.38. The average cost per registrant was $1.54, per man called was $1.69, and per man accepted for service was $4.93.

(Continued in Front Advertising Section, Page 14)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. SCATENA, M. D.
Secretary-Treasurer

Board Proceedings

In conformity with the policy of the Board of Medical Examiners to open all bottlenecks in the licensing of doctors in the State, an oral examination was held in Los Angeles on April 8, 1943. Such oral examinations are required by law of doctors applying for reciprocity on some other State of the United States, whose certificate in said State is dated more than ten years previous to the filing date in California.

The Board of Medical Examiners also went on record at its recent meeting in Los Angeles that it would give additional written examinations to candidates for licensure, whenever a sufficient number of such applications are on file, this also in an endeavor to aid in every possible way in the war effort.

News

"License of Dr. Thomas D. Wyatt to practice medicine has been restored by a writ of mandate issued by Superior Judge Edward Murphy in San Francisco, it was revealed here yesterday. The doctor, who has twice lost his license for allegedly performing illegal operations, brought action against the State Board of Medical Examiners, claiming they had exceeded their jurisdiction in revoking his license the second time. . . ." (Press dispatch from Redding, in Sacramento *Union*, March 24, 1943.)

"Warning all boards to scrutinize closely all applications for additional food rations made on a doctor's prescription, Paul Barksdale d'Orr, OPA ration chief for the Southland today listed the three types of doctors who are allowed to 'prescribe' under OPA regulations. The trio include a doctor of medicine, signing and entitled to sign M.D.; an osteopathic physician and surgeon, signing and entitled to sign physician and surgeon, D.O., or a doctor of dental surgery, signing or entitled to sign D.D.S. . . ." (Alhambra *Post-Advocate*, March 18, 1943.)

"The requirement that licensed state osteopaths have at least 30 hours of 'professional educational experience' every year should be abandoned, the assembly governmental efficiency and economy committee ruled. The bill, eliminating the annual 'refresher training' provision, was authored by Assemblyman Everett Burkhalter, Burbank, and given 'do pass' approval. It was opposed by the California Osteopathic Association. . . ." (Sacramento *Union*, March 18, 1943.)

"Approval of a plan advanced by the city council for employment of physicians to give physical examinations to prisoners when they are booked, and when they are discharged from city jails, has been voted by the police commission. . . . The suggestion was submitted by the council to the commission as the result of consideration

(Continued in Back Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

Who Says *Flavor* Isn't Important?

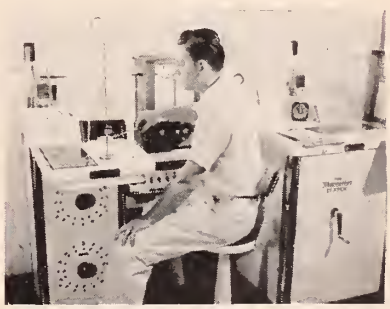


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A Limited General Hospital of 200 Beds

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GARDEN GROVE CALIFORNIA

A class "A" building affording every modern facility. Located 12 miles from Long Beach. Choice rooms from $42.50 per week including medical service. Classification of patients according to type of illness. Beautiful quiet gardens. Insulin, Metrazol and Electro Shock Therapy. For particulars address: Garden Grove Sanitarium, Garden Grove, Calif.

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Arthur C. Robbins, M.D.
John C. Kraushaar, M.D.

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 22)

pounds of candy, 1,332 pounds of chocolate, 1,327 cakes and 2,838 packages of chewing gum.

During the month of February the volume of parcel post sent to the troops in France occupied 120,000 cubic feet of space on the ships. This would be a slice of cargo space 600 feet long, 20 feet wide, and 10 feet high. The demand on tonnage of the railroads in France is so great that it frequently requires days before enough cars can be furnished to move the mail from the port to the interior of France. . . .

Excerpts from State Board of Health: April Meeting. —The State Board of Health met in Sacramento on April 6, 1918. The members present were: Dr. George E. Ebright, President; Dr. F. F. Gundrum, Vice-President; Dr. Edward F. Glaser, Dr. Adelaide Brown, and Dr. W. H. Kellogg, Secretary. . . .

Dr. W. C. Billings of the United States Public Health Service, and Medical Officer in charge of the plague eradicative work in California, appeared at the meeting and stated that he had received word from the Surgeon General that the government's appropriation for this work in California would be reduced on May 1st to a sum which would practically mean the discontinuance of this work unless the State saw fit to replace the loss by a special appropriation.

The Director of the Bureau of Registration of Nurses presented an outline of changes to be made in the schedule of studies required in training schools for nurses.

(Continued on Page 28)



From the wood engraving by Alexander Anderson, M. D., done after his ninetieth year. Dr. Anderson who lived from 1775 to 1870 was the first engraver on wood in America.

BARTER ... OR BANISHMENT

• When hay fever is treated with adrenergic drugs, in many cases the patient may discover that he has exchanged the symptoms of pollinosis for the side-effects of the medication.

In such cases a help in banishing the undesirable symptoms is by means of 'Propadrine' Hydrochloride, an efficient, synthetic preparation bearing a close structural resemblance to ephedrine but less apt to evoke undesirable side-actions such as excitation, restlessness and insomnia.

'Propadrine' Hydrochloride affords relief of asthma as well as hay fever and is also of value in allergic rhinitis.

This Sharp & Dohme product is supplied in 3/8 and 3/4-grain capsules packed in bottles of 25, 100 and 500. . . . Accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

Sharp & Dohme, Philadelphia

'PROPADRINE' HYDROCHLORIDE



Here's Why **HANDSOME BALCREST RIMLESS IS SO STURDY...**

Combining streamlined styling with sturdy construction, Balcrest Rimless fills the need for a modern screw-type rimless. Each lens is held securely by two tiny screws. Around each screw an ingenious coil spring absorbs shocks and strains. Because Balcrest has only one strap (behind the lens), it is easily assembled with lenses of any thickness.

RIGGS OPTICAL COMPANY

distributors of BAUSCH & LOMB products

PROFESSIONAL PROTECTION

SINCE 1899 SPECIALIZED SERVICE

In addition to our Professional Liability Policy for private practice, we issue a special MILITARY POLICY to the profession in the Armed Forces at a Reduced Premium

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

TWENTY-FIVE YEARS AGO

(Continued from Page 26)

The demands of the army for nurses are such as to make it absolutely necessary that all means possible be adopted to facilitate the training of nurses and increase the output of schools for nursing. . . .

A large number of successful contestants in the recent examination for the title of "Registered Nurse" was presented by the Director. By resolution the title was conferred upon them. . . .

Excerpts from an Obituary: F. Dudley Tait.—The death of F. Dudley Tait in San Francisco, on February 26, 1918, marked the passing of a forceful, and in many ways remarkable personality. Brilliant mental attainments, keen and enthusiastic appreciations of scientific medicine, and unselfish devotion to the cause of higher medical education loom large amid the stress and movement of his professional activities of more than a quarter of a century.

Dr. Tait was born in San Francisco in 1863, of English-Scotch ancestry. His father was a pioneer educator of this State, at one time superintendent of public schools of San Francisco, and later Professor of Latin in the old College of California. After some preliminary schooling in his native city, Dr. Tait was taken abroad, studied for a short time in England and Switzerland, and completed his academic education in France with the degree of B.S. . . .

Dr. Tait's professional reputation rested on firm ground. He was a daring and skillful operator possessed of a

(Continued on Page 30)

THEY DESERVE THE SMOKE THEY LIKE THE BEST*



YOUR gift of cigarettes to men in service is the most welcome of all remembrances. And the preferred brand, according to actual survey, is Camel.*

Send Camel—the cigarette noted for mellow mildness and appealing flavor. It's one way, and a good way, to express your appreciation of the sacrifices being made by our fighting forces.

Camels in cartons are featured at your local tobacco dealer's. See or telephone him—today—while you have the idea in mind.

*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. *(Based on actual sales records in Post Exchanges and Canteens.)*

• • •

Remember, you can *still* send Camels to Army personnel in the United States, and to men in the Navy, Marines, or Coast Guard *wherever they are.* The Post Office rule against mailing packages applies only to those sent to men in the overseas Army.

CAMEL COSTLIER TOBACCOS

BUY WAR BONDS AND STAMPS

EMERGENCY TREATMENT OF CONGESTIVE HEART FAILURE

CEDILANID

(Brand of Lanatoside C)

Sokolow & Chamberlain (Annals of Internal Medicine, February, 1943) states:

"According to our clinical study, the most obvious benefit of Cedilanid is derived from its intravenous use in urgent cardiac failure or when rapid, accurate dosage is desired. Its uniform potency and its purity allow greater confidence in giving large intravenous doses. The increased absorption of oral Cedilanid may prove important."

R. M. Tandowsky (American Heart Journal, October, 1942) states:

"The average time required for the development of maximal RS-T segment changes in the controls of this study after the administration of 1.6 mg. of lanatoside C intravenously was 27.5 minutes as compared to six hours and fifteen minutes after giving 16 grains of digitalis purpurea by mouth.

"In the presence of congestive failure, the intravenous administration of lanatoside C produced the maximal alteration of the RS-T segment within two to three hours, which was eleven to twelve hours sooner than when digitalis purpurea was given orally.

"Our observations indicate that lanatoside C will prove to be a valuable drug in the treatment of congestive failure, especially when quick action is desired or when gastrointestinal symptoms are troublesome."

SUPPLIED

Tablets, each containing 0.5 mg. of Lanatoside C
Ampules, 4 cc (i.v.) and 2 cc (i.m.)

Literature on Request

SANDOZ CHEMICAL WORKS, INC.

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Transporting the Sick since 1906

2570 Bush Street
SAN FRANCISCO

WEst 1400

Physicians' and Surgeons'
Telephone Exchange
Nurses' Bureau

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

ready grasp of clinical problems and a critical enthusiasm. His knowledge of surgery was most comprehensive, based on a thorough acquaintance with its literature. He was a man of indefatigable energy, restless in the search for knowledge, impatient of compromises, and intolerant of lowly accomplishments. Yet he was the most stimulating of men; again and again he has placed his time, knowledge and purse at the disposal of those who came to him for advice and assistance. No trouble or inconvenience was too great for him once he was convinced of the sincerity of the applicant. . . .

While accepting with stoic resignation the inevitable consequences of his malady, he possibly regretted beyond all else his inability to join his friends, *la bás.*

A. J. L.

It is axiomatic that the quality of health service is dependent upon the character and training of personnel responsible for rendering it.—Mayhew Derryberry.

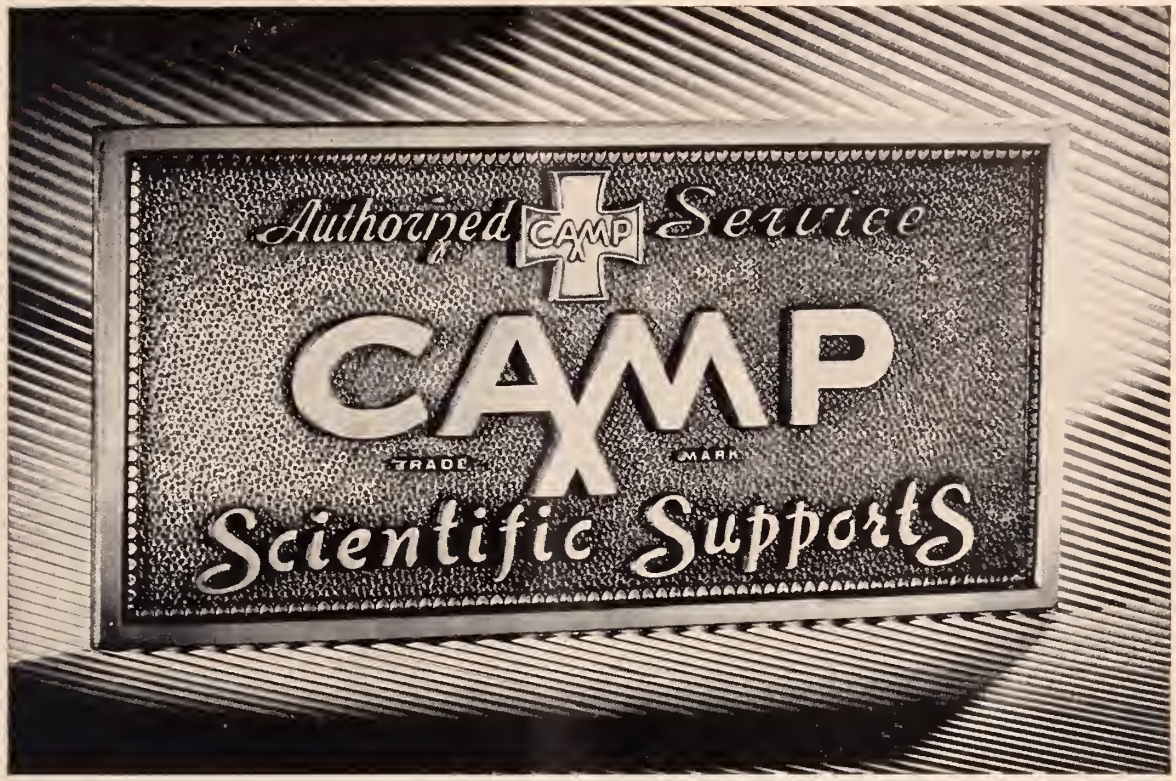
BOARD OF MEDICAL EXAMINERS

(Continued from Back Advertising Section, Page 312)

given to injuries frequently alleged to have been suffered by prisoners after their commitment to jail." (Los Angeles *Southwest Topics-Wave*, March 16, 1943.)

"Commenting on an Office of War Information announcement, that the nation's civilian health faces impairment because one-third of America's doctors are in the services, Dr. Harold Fletcher, chairman of the War Manpower Commission's California committee on physicians' procurement, declared here today San Francisco's situation 'is good.' 'As of January 1, the last check was made,' Dr. Fletcher said, 'San Francisco has 999 active doctors in regular practice, exclusive of those in public health or acting as full-time teachers. This means the city has one doctor for each 730 residents, which is well within the 1-to-1500 ratio established by the WMC for the nation. Actually, the city should keep at least 1-to-1200 because of its many war industries and also because many

(Continued on Page 32)



A Sign of Strength . . .
to endure through changing times

Consider the situation: Millions of women engaged in the heavier work of industrial jobs. Domestic help growing scarce so that even housewives work harder, longer. More maternity patients than in any time during the last two decades.

Result: More and more physicians are recommending Camp Scientific Supports according to the needs of the particular condition.

Easy to see why the symbol of Camp service is today more important than ever.

It assures doctors that every prescription for a Camp support will be filled exactly as ordered . . . by an expert, specially trained by the Camp organization.

It means that patients will find the prescribed garment available for immediate use, and at moderate prices.

Today, this responsible Camp service is a bulwark for physicians. For in an increasingly unstable field, it is filling a growing need unfailingly.

CAMP TRADE MARK *Supports*

S. H. CAMP & CO., JACKSON, MICH.
World's largest manufacturers of surgical supports.
Offices in New York, Chicago, Windsor, Ont., London, Eng.

ORTHOPEDIC **MATERNITY**
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JOHNNIE WALKER
BLENDED SCOTCH WHISKY

THE FLAVOR of Johnnie Walker is *different*. One small sip tells you that it is a *distinctive* whisky . . . Scotch at its smooth, mellow best! Distilled and bottled in Scotland. Enjoyed all over America!



RED LABEL 8 YEARS OLD

BLACK LABEL 12 YEARS OLD

Both 86.8 proof

Canada Dry Ginger Ale, Inc., New York, N. Y. • *Sole Importer*

May We Suggest CALSO WATER for the Urologists

Indications

For all Genito-urinary infections, particularly the irriated bladder of Prostatics

Pre- and Postoperative Treatment

Fluid Depletion

Indicated in combinations with Sulfa therapy

Formula

Calcium Carbonate
Magnesium Carbonate
Sodium Chloride
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Sparkling Palatable Not a Laxative

•

THE CALSO COMPANY
524 Gough St., San Francisco, Calif.

CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

nearby cities' residents come here for treatment and diagnosis.' Dr. Fletcher said that California as a whole has an adequate number of physicians and surgeons. War-crowded areas, such as Vallejo, Richmond, Marin City and San Diego, he said, are being supplied by coöperation with the California Physicians' Service and the health insurance agency sponsored by the California Medical Association. The only worry, he said, lies in a few isolated communities 'where doctors went into the war before we had a chance to stop them.' The Army and Navy no longer will accept doctors' enlistments without a clearance from the WMC, Dr. Fletcher said." (San Francisco *News*, March 30, 1943.)

During Food Shortages.—It is well to bear in mind that dried brewers yeast, weight for weight, is the richest food source of the Vitamin B Complex. For example, as little as 1 level teaspoonful (2.5 Gm.) Mead's Brewers Yeast Powder supplies: 45 per cent of the average adult daily thiamine allowance, 8 per cent of the average adult daily riboflavin allowance, 10 per cent of the average adult daily niacin allowance.

This is in addition to the other factors that occur naturally in yeast such as pyrodoxin, pantothenic acid, etc.

Send for tested wartime recipes, the flavors of which are not affected by the inclusion of Mead's Brewers Yeast Powder. Mead Johnson & Company, Evansville, Ind., U. S. A.

Salute, Doctor!

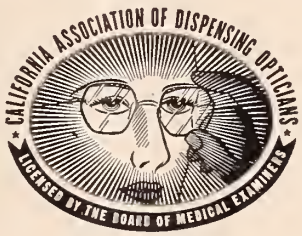
TODAY thousands newly employed in exacting work, having never before noticed fractional eyesight errors, are hastening to eye physicians to improve the quality of their important production. Hard-pressed medical eye specialists are today doing a great job—comparable in military importance to the history-making work of their colleagues in the armed forces. We salute the American Ophthalmologist.

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SAN FRANCISCO,
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A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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ALUM ROCK SANATORIUM

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A small select sanatorium for the treatment of Tuberculosis and other chest diseases.

Each patient receives individual study and care. The referring physician receives regular clinical reports.

Climate is ideal. Located at 1,000 ft. elevation, 6 miles east of San Jose, overlooking the Santa Clara Valley. A folder will be sent on request.

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Army-Navy "E" Award to Don Baxter, Inc.—In an impressive presentation ceremony at its laboratories in Glendale, California, Don Baxter, Inc., received the coveted Army-Navy "E" Award for great accomplishment in the production of intravenous solutions and blood and plasma equipment for the Armed Forces.

Colonel Robert Skelton (MC), Commanding Officer of the San Francisco Army Medical Depot, made the Award Presentation Address. Commander Corydon M. Wassell (MC), USNR, addressed the audience and presented the "E" lapel pins to the employees of Don Baxter, Inc.

The high honor bestowed upon Don Baxter, Inc., is especially significant because this is the first Army-Navy "E" to be awarded to a Western manufacturer of medical supplies. Don Baxter, Inc., it will be recalled, was the first manufacturer of ready-to-use intravenous solutions, and the modern "closed systems" of blood transfusing and preparing plasma are Baxter developments.

In accepting the award, Emery S. Beardsley, President and General Manager of Don Baxter, Inc., pointed out that while serving the Army and Navy with distinction, the company continues to meet fully the ever-increasing requirements of civilian hospitals and medical centers in the West.

Clinical Evaluation of 'Seconal Sodium.'—During the course of a year, Dietrich (Anesth. & Analg., *22*:28, 1943), attempted to evaluate 'Seconal Sodium' (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly), as a sedative in general pediatric practice. Over 3,700 doses of the drug were administered to more than 500 children and

(Continued on Page 36)

FOR INFANTS *and* FOR CHILDREN



Milk diffusible VITAMIN D *preparation*

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

DRISDOL IN PROPYLENE GLYCOL

DOES NOT FLOAT ON MILK • DOES NOT ADHERE TO BOTTLE

DOES NOT HAVE A FISHY TASTE • DOES NOT HAVE A FISHY ODOR

Drisdol in Propylene Glycol—10,000 units per Gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.



This cherished symbol of distinguished service to our Country waves from the Winthrop flagstoff.

DRISDOL

Reg. U. S. Pat. Off. & Canada

IN PROPYLENE GLYCOL

Brand of Crystalline Vitamin D from ergosterol

WINTHROP CHEMICAL COMPANY, INC.

NEW YORK, N. Y. *Pharmaceuticals of merit for the physician* WINDSOR, ONT.

The Alexander Sanatorium, Inc.

Situated in the Foothills of
BELMONT, CALIFORNIA

Specialized care of Convalescents; also NERVOUS, MENTAL and ALCOHOLIC Patients. Experienced Staff for the application of INSULIN and ELECTRIC SHOCK Therapies and for the CONDITIONED REFLEX TREATMENT of ALCOHOLISM.

Recognized by the American Medical Association; Member of Association of Private Mental Hospitals and of the Western Hospital Association.

MRS. A. S. ALEXANDER, *President* Telephone: Belmont 40

THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest ***Monrovia, California***

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

(Established 1903)

CHOICE rooms and bungalows at rates ranging from $37.50 up, including routine medical and nursing services, intermin physical, x-ray and laboratory examinations, ordinary medicines and pneumothorax. A charge is made for the first complete examination.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases. Separate institution for children.

For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

CLINICAL EVALUATION OF "SECONAL SODIUM"

(Continued from Page 34)

infants, both private and ward patients, without any untoward effects on pulse, temperature, blood pressure, or cerebrospinal fluid pressure. The drug proved to be an excellent general sedative possessed of some analgesic action, and in tetanus and in the performance of certain otherwise painful procedures where a general anesthetic was not desirable, such as pinch grafts, lumbar punctures, myringotomies, and incision and drainage of minor abscesses, it was of particular value.

When the age of the patient and freedom from gastric symptoms permit, 'Seconal Sodium' should be given by mouth. When administered by rectum, however, its action is only slightly retarded. The intact capsule may be inserted in the manner of a suppository by first pricking each end of the capsule with a pin; or, where fractional doses are desired, the powder may be suspended in tap water and given by rectum with a small syringe.

For literature, address Eli Lilly and Company, Indianapolis, Indiana.

Another Quantity Production Triumph for Detroit.—That the voluntary patriotic service of the drug industry ranges all the way from the retailer selling war stamps across the counter to the drug manufacturer giving generously of his time and money to blood donor work is evident by the record of the American Red Cross Blood Donor Station at Detroit.

The motor city, headlined more for its war plants than for its several great pharmaceutical houses, stands second only to New York City in volume of blood donations, even though only fourth among American cities in population.

Chairman of the Detroit Blood Donor Volunteer Service Committee is Frederick S. Stearns, who is also chairman of the board of Frederick Stearns & Company, 88-year-old Detroit drug manufacturing concern.

Mr. Stearns assumed the chairmanship of the Detroit Blood Donor Station in January, 1942.

By mid-April the total number of blood donors in the Detroit area had reached 162,153, which means that allowing for those unable to meet the medical qualifications of donors, upwards of 200,000 had volunteered. In the record month of March, 24,181 volunteers had donated 21,298 pints of blood, matching the ceiling quota of 5,000 pints a week, a quota limited by the capacity of available processing equipment.

Chairman Stearns credits the enviable Detroit showing to the application of a merchandising principle essential to any successful selling enterprise: Correct treatment of the "customer" so that he keeps coming back.

Of the 21,000 donors in March, more than 9,000 were "repeaters." In one period, 65 per cent of all donors had volunteered one or more times previously. On one winter day, when subzero temperatures sent war plant absenteeism to alarming figures, the base station at 450 W. Fort Street had 280 donors scheduled. The number processed that day was 286. . . .

This volunteer work, on which Mr. Stearns covers an extra 1,000 miles a month, is superimposed on his regular duties as chairman of the board of Frederick Stearns & Company. Perhaps the fact that his own two boys are in the armed forces has something to do with it. One is a

(Continued on Page 40)

NOT A WAR-BORN IDEA

Personalized Field Service on G-E Equipment Has Prevailed for Many Years

It is important that x-ray and other electromedical equipment be kept in tip-top operating condition during these busy days in hospitals, clinics, and physicians' offices. And to users of G-E equipment the need for expert technical and maintenance service in this wartime period has presented no problem. They continue to get it from the same G-E branch offices and regional service depots that have taken care of them for many years past.

In other words, this idea of G-E field service is not something set up *just for the duration.* It is considered quite as important to G-E customers in peacetime as well.

G-E Periodical Inspection and Adjustment Service, for example, is a low-cost, year-round service that keeps thousands of G-E x-ray and electromedical units at highest operating efficiency at all times. Thus investments in fine equipment are protected, to preclude costly and annoying breakdowns.

Therefore, to present and future users of G-E equipment, this competent field service will always be available—in wartime and peacetime, both.

ARMY E NAVY

GENERAL ELECTRIC X-RAY CORPORATION



In your particular area the following G-E Branches and Regional Service Depots stand ready to serve you:

LOS ANGELES
Wilshire Medical Building
658 S. Westlake Avenue

SAN DIEGO
4865 Alice Street

SAN FRANCISCO
450 Sutter Street

SACRAMENTO
Sutter Club

BERKELEY
420 Coventry Road

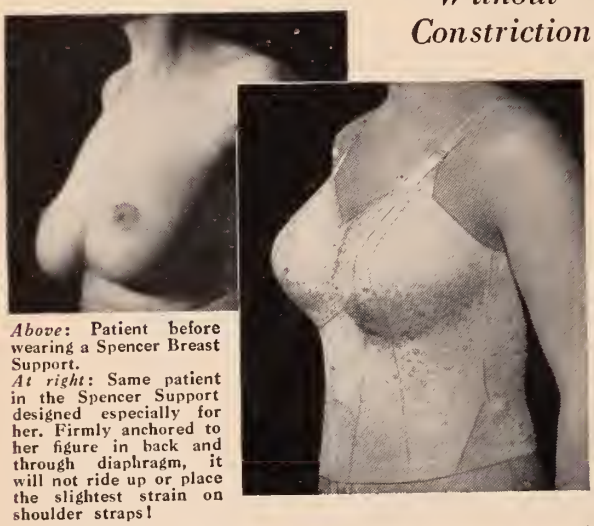
FRESNO
Box 524, Fowler Avenue

SALT LAKE CITY, UTAH
421 Judge Building
Main & Third South Streets

Today's Best Buy – U.S. War Bonds

DEFINITE UPLIFT FOR THE HEAVIEST PTOSED BREASTS!

This Spencer Support Holds Breasts in Natural Position Without Constriction



Above: Patient before wearing a Spencer Breast Support.
At right: Same patient in the Spencer Support designed especially for her. Firmly anchored to her figure in back and through diaphragm, it will not ride up or place the slightest strain on shoulder straps!

IMPROVES CIRCULATION of the blood through the breasts, lessening the chance of the formation of non-malignant nodules, and improving tone.

PROVIDES COMFORT AND AIDS BREATHING when worn by women who have large ptosed breasts.

AIDS MATERNITY PATIENTS by protecting inner tissues and helping prevent outer skin from stretching and breaking.

HELPS NURSING MOTHERS by guarding against caking and abscessing.

Individually designed for each patient.

Spencer Supports are never sold in stores. For a Spencer Specialist, look in telephone book under "Spencer Corsetiere" or write us direct.

SPENCER *INDIVIDUALLY DESIGNED*

Abdominal, Back and Breast Supports

SPENCER INCORPORATED,
137 Derby Ave., New Haven, Conn.
In Canada: Rock Island, Quebec.
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May We Send You Booklet?

Please send me booklet, "How Spencer Supports Aid the Doctor's Treatment."

.....M. D.

Address P-5

Bequest Forms: Unto the Physicians' Benevolence Fund of the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $——— for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees of the California Medical Association, a nonprofit corporation of California, the sum of $———, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be paid to and become a part of the Physicians' Benevolence Fund of the California Medical Association as said fund is established and maintained by said Association.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I hereby give and bequeath unto the Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be expended by said corporation for the benefit and as a part of the Physicians' Benevolence Fund of the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California, for the use and benefit of the Physicians' Benevolence Fund of the California Medical Association the following described real property situated in the County of ————, State of California, and more particularly described as follows, to-wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I hereby give and devise unto Trustees of the California Medical Association, a nonprofit corporation of California (here describe the property), the same or the proceeds thereof to be held as a part of the Physicians' Benevolence Fund of the California Medical Association, the income whereof shall be used for the purposes of said fund as it is established and maintained by the California Medical Association. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* Correspondence for the Physicians' Benevolence Committee may be addressed to the C. M. A. office or to Axcel E. Anderson, Chairman, 1759 Fulton St., Fresno.

Cheplin's

AMINOPHYLLINE

(Theophylline with Ethylenediamine)



An Effective Diuretic

Aminophylline is a vasodilator of coronary vessels which has often proved useful for relieving the cardiac pain due to coronary sclerosis. Its action is essentially the same as theophylline and theophylline with sodium acetate, over which it has the advantage of greater solubility.

Recently, the therapeutic scope of Aminophylline has been broadened considerably. It has been shown to have a favorable influence upon respiratory dysfunctions, such as Asthma, Paroxysmal Dyspnea and Cheyne-Stokes Respiration.

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AMPULES—In 2 cc. ompules (for intromuscutor use) contoining 7½ gr. (0.48 Gm.), in boxes of 12, 25 ond 100.
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(Continued from Page 36)

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Challenging Problems in Global Warfare.—How American medicine has met many challenging problems imposed by this global war was described by Albert Q. Maisel, war correspondent and author of "Miracles of Military Medicine," at a banquet for employees of Ciba Pharmaceutical Products, Inc., celebrating the presentation of the Army-Navy "E" to the company.

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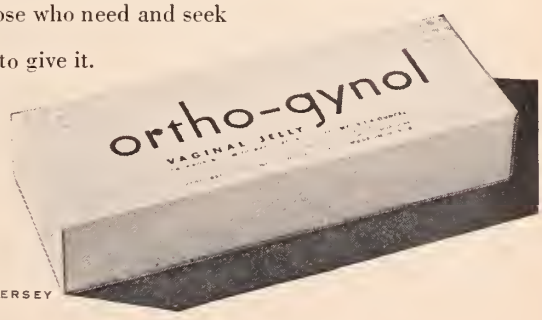
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*Himes—Medical History of Contraception

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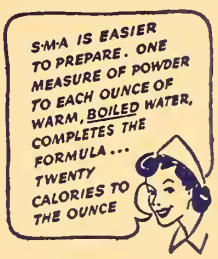
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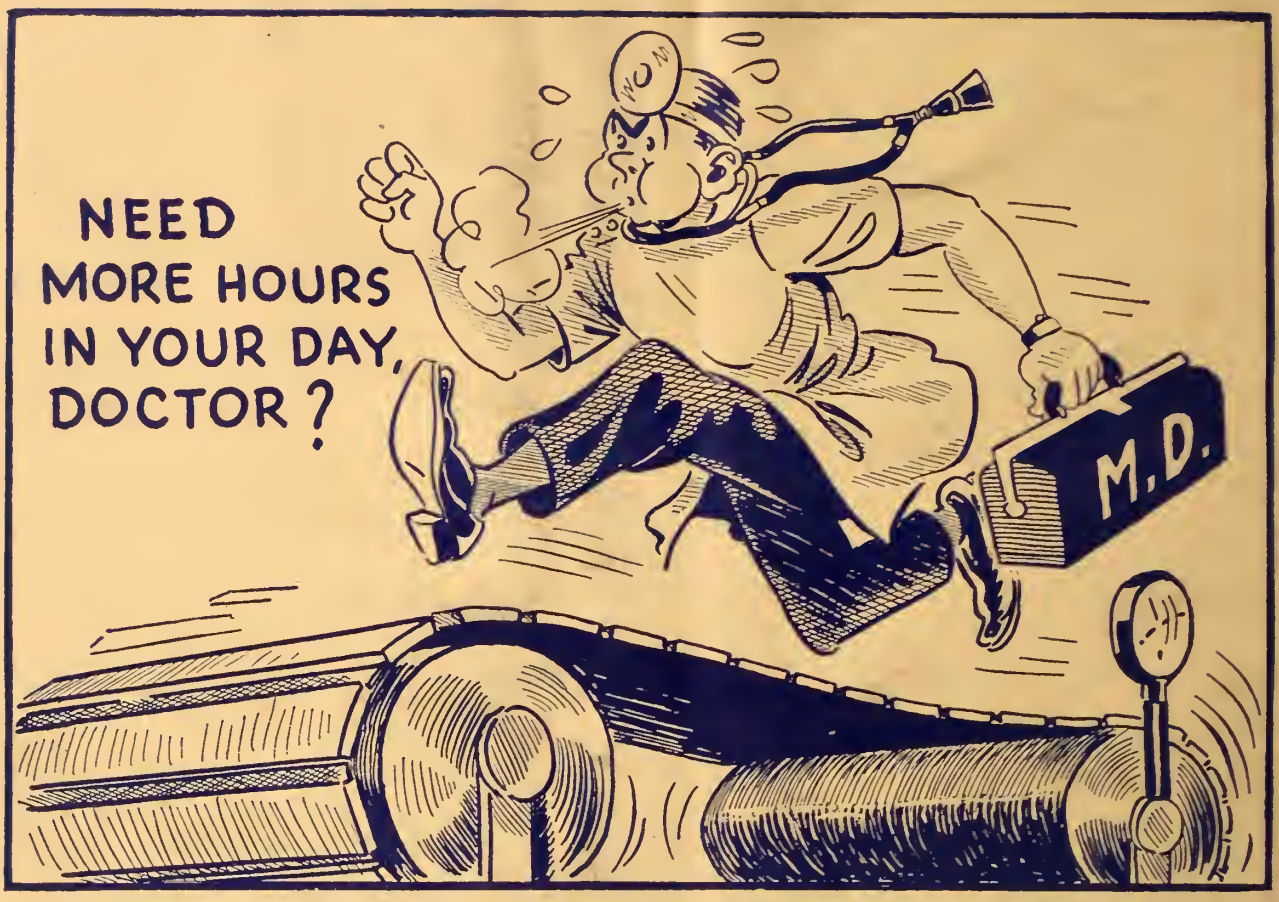
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(Continued on Page 5)

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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, Clifford W. Mack, Livermore Sanitarium, Livermore.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn Medical Society
President, Charles E. Plumb, 310 Main Street, Chico.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Secretary, J. M. Boomer, American Trust Building, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, William G. Milholland, 711 Bank of America Building, Fresno.
Secretary, Jerome A. Thormann, Power Company Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Charles C. Falk, Sr., 507 F Street, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, T. E. Bartholomew, 319 Third Street, Calexico.
Secretary, Henry Forcher, 319 Third Street, Calexico.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, William I. Shultz, 408 N. Main Street, Bishop.
Secretary, Joseph W. Telford, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, J. M. Nicholson, Haberfelde Building, Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 7:00 p. m., Padre Hotel.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, G. R. Fortson, Susanville.*
Secretary, J. W. Crever, Susanville.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, E. Vincent Askey, 2212 W. 3rd Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Rodney B. Hartman, 38 Bigelow, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, 6:30 p. m., Blue Rock Hotel, Larkspur.*

Mendocino-Lake County Medical Society
President, John H. Lloyd, Fort Bragg.
Secretary, Louise E. Petty, Talmage.
Meeting, *On Call.*

* Deceased.

Merced County Medical Society
President, J. J. McNearney, 311 Shaffer Building, Merced.
Secretary, C. C. Fitzgibbon, Shaffer Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Rollin Reeves, 32 E. San Luis Street, Salinas.
Secretary, S. Condit Glasgow, 8 E. Alisal Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, I. E. Charlesworth, Napa State Hospital, Imola.*
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, D. A. Harwood, 214 E. Walnut, Santa Ana
Secretary, L. F. Whittaker, 302 Third Street, Huntington Beach.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, Wayne K. Templeton, 3770 12th Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Edward S. Babcock, 1127—11th Street, Sacramento.
Secretary, Carl E. Burkland, 510 Medico-Dental Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.*
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, W. Don Rolph, 640 National Ave., National City.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
President, Sidney J. Shipman, 490 Post Street, San Francisco.
Secretary, Chester L. Cooley, 490 Post Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Curtis M. Galt, 134 N. Lincoln Avenue, Manteca.
Secretary, Dora A. Lee, 110 North San Joaquin Street, Stockton.
Meeting, *First Thursday, 8:15 p.m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. F. Ragsdale, 717 Twelfth Street, Paso Robles.
Secretary, Harrison Eilers, Box 360, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, William A. Key, 23 Second Avenue, San Mateo.
Secretary, Logan Gray, 57 Fourth Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Lawrence F. Eder,* 1421 State Street, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Association
President, J. Irving Beattie, 652 E. Santa Clara Street, San Jose.
Secretary, John Hunt Shephard, 241 E. Santa Clara Street, San Jose.

Santa Cruz County Medical Society
President, F. P. Shenk, Medico-Dental Building, Santa Cruz.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meetings: *February, April, October, and December. Time and place to be decided by the President.*

Shasta County Medical Society
President, Oscar Jess Hansen, 1726 Market Street, Redding.
Secretary, John E. Kirkpatrick, Shasta Dam.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, H. L. Vidricksen, Weed Hospital, Weed.
Secretary, F. W. Martin, Mt. Shasta.
Meeting, *Sunday on Call.*

Solano County Medical Society
President, Cary A. Snoddy, 405 Georgia Street, Vallejo.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Thursday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Clifford M. Carlson, 576 B Street, Santa Rosa.
Secretary, E. D. Barnett, 3325 Chanate Road, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Terry T. Laird, Oakdale.
Secretary, Hoyt R. Gant, 401 Beaty Building, Modesto
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, Frank L. Doane, Red Bluff.
Secretary, R. G. Frey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Karl F. Weiss, 222 West Willow Street, Visalia.
Secretary, Frank R. Guido, 310 W. Willow Street, Visalia.

Ventura County Medical Society
President, G. C. Coffey, Bank of America Building, Ventura.
Secretary, M. M. Raines, 34 North Ash Street, Ventura.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Ray E. Nichols, Woodland.
Secretary, Alfred E. Leivers, Woodland Clinic, Woodland.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, John W. Lindstrum, 423 Fourth Street, Marysville.
Secretary, Joseph J. Salopek, 423 Fourth Street, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising Page 6)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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In California, the three nonprofit hospitalization corporations named below are in operation:

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Chairman, Ernest H. Warnock, 1136 West Sixth Street, Los Angeles.
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Chairman, Karl Otto von Hagen, 727 West Seventh Street, Los Angeles.
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Obstetrics and Gynecology

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Secretary, Roy E. Fallas, 1930 Wilshire Boulevard. Los Angeles.

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Chairman, Jesse L. Carr, University of California Hospital, San Francisco.
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Corresponding Secretary, Mrs. Charles Rees, 4496 Trias Street, San Diego.

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Butte-Glenn County—Mrs. J. O. Chiapella, 318 Sowellino Ave., Chico.
Contra Costa County—Mrs. S. M. Weil, Box 188, Rodeo.
Fresno County—Mrs. R. W. Dahlgren, 636 Normal St., Fresno.
Humboldt County—Mrs. J. S. Chain, 2220 E St., Eureka.
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Siskiyou County—Mrs. F. W. Martin, Mt. Shasta.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.

Sacramento—1020 N St., Phone 2-4711.

Los Angeles—State Office Building, 217 West First Street, MAdison 1281.

President, Elmer Belt, Los Angeles

Director, Wilton L. Halverson. 603 Phelan Building, 760 Market Street, San Francisco

California Northern District Medical Society

President—John H. White, Chico.

Secretary—J. Homer Woolsey, Woodland Clinic. Woodland.

Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.

Los Angeles, 906 State Building.

Sacramento, Business and Professional Building, 1020 N Street.

Secretary, Frederick N. Scatena, M.D., 1127 Eleventh Street, Sacramento.

Southern California Medical Association

President, Ray B. McCarty, 3116 Main Street, Riverside

Secretary, Nelson Paul Anderson, 2007 Wilshire Blvd., Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Francis S. Smyth, M.D., Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Seeley G. Mudd, M. D., Dean.
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BOOK REVIEWS

BOOKS RECEIVED

Seventieth Annual Report of the Commissioner of the Michigan Department of Health for the Fiscal Year ending June 30, 1943. Cloth. Pp. 470. Lansing, Michigan: Franklin Dekleine Company, 1942.

A Guide to Practical Nutrition. A series of articles on nutrition, sponsored by the Committee on Nutrition and Deficiency Diseases of The Philadelphia County Medical Society. Edited for the Committee by Michael G. Wohl, M.D., and John H. Willard, M.D. Introduction by Morris Fishbein, M.D., Editor, Journal of the American Medical Association. Reprinted from "Philadelphia Medicine," 1941-1942. Paper. Pp. 98. Philadelphia: The Philadelphia County Medical Society, 1943.

Tuberculosis as it Comes and Goes. By Edward W. Hayes, B.S., M.D., F.A.C.P., Associate Professor of Tuberculosis, College of Medical Evangelists, Los Angeles; Member of the attending staff Los Angeles General Hospital, Division of Tuberculosis; Physician in charge of the Tuberculosis Clinic and Sanatorium of the Orange County Hospital, Orange, California; Director of Tuberculosis, Imperial County, California; Medical Director and Physician in charge of the Maryknoll Sisters Sanatorium and the Keane Sanatorium, Monrovia, California. Cloth. Pp. 187, illustrated. Livingston, Columbia County, New York, U. S. A.: The Livingston Press, 1943.

Vital Statistics of the United States, 1940. Part I. Natality and Mortality Data for the United States Tabulated by Place of Occurrence with Supplemental Tables

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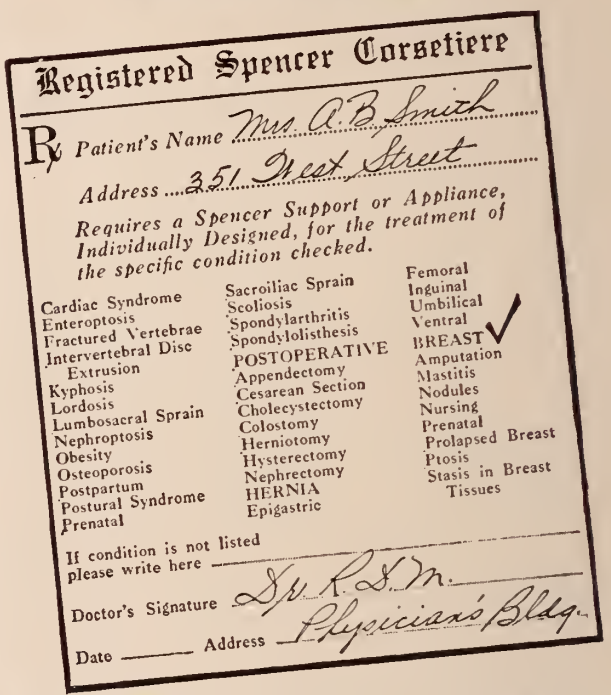
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BOOKS RECEIVED

(Continued from Page 7)

for Hawaii, Puerto Rico, and the Virgin Islands. Prepared under the supervision of Halbert L. Dunn, M.D., Chief Statistician for Vital Statistics. Cloth. Price $2.00. Pp. 657. Washington, D. C.: United States Government Printing Office, 1943.

Skin Grafting of Burns: Primary Care—Treatment—Repair. By James Barrett Brown, M.D., Lieutenant Colonel, Medical Corps, Army of the United States; Senior Consultant in Plastic and Maxillo-facial Injuries and Burns, E.T.O. U.S.A., Associate Professor of Surgery, Washington University, St. Louis, Missouri; and Frank McDowell, M.D., Assistant in Clinical Surgery, Washington University, St. Louis, Missouri. Cloth. Price $5.00. Pp. 204, with 131 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

First Aid Surgical and Medical. By Warren H. Cole, M.D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Director of Surgical Service, Illinois Research and Educational Hospitals, Chicago; and Lieutenant Colonel Charles B. Puestow, Medical Corps, Army of the United States. Second Edition. Cloth. Price $3.00. Pp. 351, with illustrations by Carl Linden in collaboration with Tom Jones of the Illustration Studios of the University of Illinois College of Medicine, Chicago. New York, London: D. Appleton-Century Company, Incorporated, 1943.

Hope Deferred. By Jeanette Seletz. Cloth. Price $2.75. Pp. 536. New York: The Macmillan Company, 1943.

A Manual of Otology, Rhinology and Laryngology. By Howard Charles Ballenger, M.D., F.A.C.S., Associate Professor of Otolaryngology, Northwestern University School of Medicine, Chicago, Illinois. Surgeon, Department of Otolaryngology, Evanston Hospital, Evanston, Illinois.

(Continued on Page 14)

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Kantor, J. L.: Digestive Disease and Military Service, Jnl. A. M. A., Sept. 26, 1942.

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Revised and Edited by Burgess Gordon, M.D., Jefferson Medical College, Philadelphia, 36 Illus., 796 Pages, $5.75 (1942)

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BOOKS RECEIVED

(Continued from Page 10)

Second Edition, enlarged and thoroughly revised. Cloth. Price $4.00. Pp. 334, illustrated with 114 engravings and 3 color plates. Philadelphia: Lea & Febiger, 1943.

Outline of Roentgen Diagnosis. An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. By Leo G. Rigler, B.S., M.B., M.D., Professor of Radiology, University of Minnesota, Minneapolis, Minnesota. Second Edition. Cloth. Price $6.50. Pp. 196, with 254 illustrations shown in 227 figures, presented in drawings and reproductions of roentgenograms, figures 6 to 51 and 55 to 72 are drawings in an original technique by Jean E. Hirsch. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

A Study of Endometriosis, Endosalpingiosis, Endocervicosis, and Peritoneo-ovarian Sclerosis. A Clinical and Pathologic Study. By James Robert Goodall, O.B.E., B.A., M.D., C.M., D.Sc., F.I.C.S. (Hon.), F.R.C.O.G., Formerly Professor of Clinical Gynecology and Obstetrics, McGill University; Consulting Staff in Gynecology and Obstetrics, Royal Victoria Montreal Maternity Hospital; Consulting Gynecologist and Obstetrician to the Homeopathic Hospital, Montreal; Consultant in Charge of Gynecology in St. Mary's Hospital, Montreal; Life-fellow of the American Gynecological Society; Fellow of the American Association of Gynecologists, Obstetricians, and Abdominal Surgeons; Foundation Fellow of the Royal College of Obstetricians and Gynecologists; Honorary Fellow of the International College of Surgeons; member of the Montreal Medico-Chirurgical Society; Consultant to the Saranac General Hospital, Saranac, N. Y.; Consultant to the Alice Hyde General Hospital, Malone, N. Y. Cloth. Price $5.50. Pp. 140, with 13 illustrations in black and white and 17 subjects in full color on 6 plates. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Essentials of Industrial Health. By C. O. Sappington, M.D., Dr. P.H., Consulting Industrial Hygienist, President, Central States Society of Industrial Medicine and

(Continued on Page 16)

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Surgery, Editor of "Industrial Medicine." Cloth. Price $6.50. Pp. 626, with 63 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

Convulsive Seizures: How to Deal with Them. A Manual for Patients, Their Families and Friends. By Tracy J. Putnam, M.D., Professor of Neurology and Neurosurgery, College of Physicians and Surgeons, Columbia University; Director of Services of Neurology and Neurosurgery, Neurological Institute of New York. Cloth. Price $2.00. Pp. 158, with 12 illustrations. Philadelphia: J. B. Lippincott Company, 1943.

Urology in General Practice. By Nelse F. Ockerblad, B.S., M.D., F.A.C.S., Professor of Clinical Urology, University of Kansas School of Medicine; Senior Attending Urologist at St. Luke's Hospital; Consulting Urologist to the Children's Mercy Hospital, Kansas City, Missouri: Diplomate of the American Board of Urology; and Hjalmar E. Carlson, B.S., A.M., M.D., F.A.C.S., Instructor in Urology, University of Kansas School of Medicine: Attending Urologist to St. Luke's Hospital and Trinity Hospital, Kansas City, Missouri: Diplomate of the American Board of Urology. Cloth. Price $4.00. Pp. 383, illustrated. Chicago: The Year Book Publishers, Inc., 1943.

Your Arthritis: What You Can Do About It. By Alfred E. Phelps, M.D. With an Introduction by R. Garfield Snyder, M.D. Cloth. Price $2.00. Pp. 192, with illustrations by James MacDonald. New York: William Morrow and Company, 1943.

Essentials of Syphilology. By Rudolph H. Kampneier, A.B., M.D., Associate Professor of Medicine, Vanderbilt University School of Medicine: in Charge of the Syphilis Clinic and Visiting Physician to Vanderbilt University Hospital; with Chapters by Alvin E. Keller, M.D., and J. Cyril Peterson, M.D. Cloth. Price $5.00. Pp. 518, with 87 illustrations. Philadelphia, London, Montreal: J. B. Lippincott Company, 1943.

(Continued on Page 18)



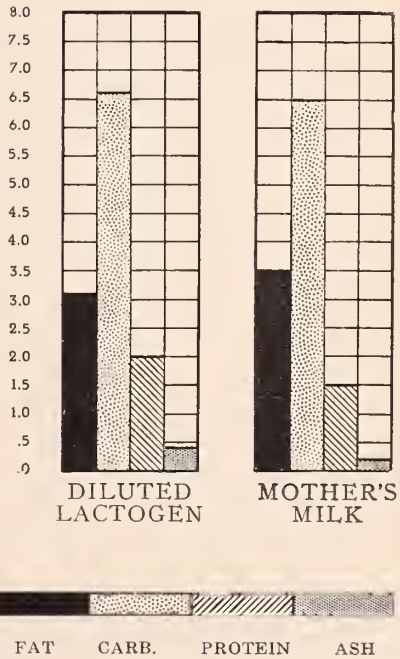


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Clinical Pediatrics, p. 156

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BOOK REVIEWS

(Continued from Page 16)

Transurethral Prostatectomy. By Reed M. Nesbit, Charles C. Thomas, Publisher.

This book merits an encomium. It is clear, straightforward and complete. It leaves no queries or uncertainties. It is a masterpiece, an *opus magnum* of Urology. The first systematized method of procedure ever advocated for transurethral resection cannot fail to benefit this branch of surgery.

The one great cause of death after prostatectomy by any method is hemorrhage. Nesbit establishes the logic of his system for the control of hemorrhage before anything is said about the system itself, by the anatomical presentation (in Chapter I, by Rubin H. Flocks) of the blood supply to the enlarged prostate, clearly illustrated by Didusch and by the photograph of a postmortem specimen. The reader perceives at once the reason of his routine method of resection. Speed and thoroughness are promoted thereby. Before presenting the system which he follows Nesbit outlines *The Armamentarium*, in Chapter II; *The Use of the Resectoscope*, in Chapter III (here are discussed many useful tricks of the trade, all of great merit); *Diagnosis and Selection of Operation for the Treatment of Prostatism*, in Chapter IV ("In the period 1938-1941, 83 per cent of the patients in the University Hospital who were operated upon for nonmalignant prostatic obstruction were treated by resection, 10 per cent by perineal prostatectomy and 7 per cent by suprapubic operation"); *Anesthesia*, in Chapter V (low spinal or pentothal); *Preoperative Management*, in Chapter VI (with emphasis of adequate intake

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

of fluids). In Chapter VIII, the routine system of procedure, *A Technique of Transurethral Prostatectomy*, is presented and the illustrations by Didusch are as plain as day. The essence of Nesbit's technique is the early and immediate control of bleeding by use of an encircling maneuver which so avascularizes large masses of tissue as to permit their resection with great rapidity. He recognizes three major zones of operation, the intravesical zone (all tissue which projects into the bladder and is surrounded by the internal sphincter); the subvesical zone (all tissue which is left distal to the internal sphincter lying within the prostatic capsule; and the apical zone (all tissue which remains proximal and adjacent to the external sphincter). Each zone is attacked in the foregoing order, the primary object in the succession being the delineation of the boundaries of each field of operation, the secondary object, complete speedy removal. The system is modified to meet certain conditions such as a series of two or more encircling maneuvers in removing large glands. The advantages of his modification of the instrument so that it can be worked by one hand, thus permitting a finger in the rectum when resecting the apical zone, are obvious.

Chapter VIII deals with Postoperative Management; Chapter IX, with Complications; and Chapter X, with Cancer. ("It is the author's opinion that when the lesion is small; is confined within the prostatic capsule; and does not show evidence of local or remote metastases, perineal exposure of the prostate gland is indicated.") Chapter XI is the written record of 12 years' effort to

(Continued on Page 22)

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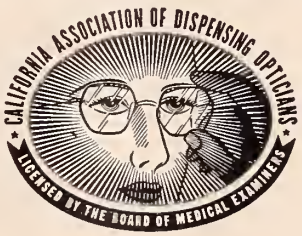
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** In Military Service*

BOOK REVIEWS

(Continued from Page 20)

attain an ideal, a perfect postoperative result in every patient. Perhaps no surgical procedure ever can be 100 per cent perfect; but here a perfectionist shows a most worthy accomplishment. He reports 645 operations with 8 deaths (1.2 per cent). In a group of 100 consecutive patients who were questioned, only 10 per cent found their sexual potency diminished, none was incontinent. Truly this is a triumph of modern urology.

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(Continued in Back Advertising Section, Page 26)



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EDITOR GEORGE H. KRESS

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Committee on Publications

George W. Walker (Chairman)	Fresno	1946
F. Burton Jones	Vallejo	1944
Francis E. Toomey	San Diego	1945

Secretary and Editor ex officio

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its offices requesting a copy of this leaflet.

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EDITORIALS

72ND ANNUAL SESSION OF C.M.A.: OFFICIAL PROCEEDINGS

Verdict Concerning the Session was Most Favorable.—Gratifying in recollection are the memories of the two-day streamlined annual session, held this year in Los Angeles, on Sunday-Monday, May 2nd-3rd, with headquarters at Hotel Biltmore. Pessimistic prognostications by some members that the attendance would be extremely small were proven erroneous by the fact that 1,184 physicians signed registration cards. The Woman's Auxiliary was credited with a registration of 134; and at the "Dinner to the C.M.A. President," on Sunday evening, a total of 934 physicians and guests were seated.

* * *

Keynote of Meetings was Military Medicine.—In the general and section meetings, topics related to military medicine were emphasized. So also as regards the scientific exhibits, where the displays by the United States Navy and Army, American Red Cross, California Office of Civilian Defense, and allied activities were visited by nearly all who were present. The films loaned by the Navy and the University of California were likewise most interesting.

A pleasing episode at the first general meeting was the presentation of a check for $1,000.00 to the Physicians' Benevolence Fund by the Woman's Auxiliary; which will hereafter receive further support from the State Association through the yearly allocation of one dollar from each active member's dues.

Concensus of opinion by physicians and also by section officers was that the meetings were informative, stimulating and most worth-while.

* * *

Official Proceedings.—As in the past, the House of Delegates held two sessions; and the C.M.A. Council convened for business at four different times. Elsewhere in this issue appear the minutes of the meetings, with the exception of proceedings when the House was in executive session. Many matters of vital importance to the interests of the medical profession and public health were taken up. Members are urged to at least scan the minutes because it is desirable, in times such as the present, that all physicians be alert to impending changes in practice. The black face headings of resolutions and subjects which were under discussion make it easy to pick out for more careful perusal, items that may have special interest. (See pages 345-366.)

Because of lack of time, final consideration on a number of matters was not possible, the House referring decision and future procedures to the Council, with power to act. The Council will hold a two-day meeting in San Francisco on Saturday-Sunday, June 19th-20th, at which time these problems will be fully discussed. Invitations have been sent to interested parties in order to give all organizations concerned, full opportunity to present their views. Conclusions reached will appear in later issues of the OFFICIAL JOURNAL.

FATE OF PUBLIC HEALTH MEASURES IN RECENT CALIFORNIA LEGISLATURE

As in Former Years, Much Public Health Legislation was Proposed.—On May 8, 1943 (by the Legislature's clock, however, May 5th), the biennial session of the California Legislature, which began its work in January, adjourned.

Although this 55th legislative session was supposedly streamlined, a total of 3,397 proposed laws were submitted, and about 10 per cent of these had public health and medical practice implications. A report of the major measures in which physicians have natural interest is given in this issue in the department of the Committee on Public Policy and Legislation. (See page 372.)

While the California Medical Association itself submitted no legislative bills, it maintained an active interest throughout the session and watched carefully the course of measures in which public health or medical standards were involved.

* * *

Some of the Special Measures.—Attention may be called again to the amendments to California's medical practice act which were proposed by the State Board of Medical Examiners. Heretofore, inconvenience and hardships sometimes have resulted because of the infrequent three or four Board examinations held each year. Under the new law (A.B. 1171) the State Board is empowered to create committees to pass on qualifications and give examinations, thus making possible more frequent examinations; the Board also receiving the legal right to vote on qualifications by mail.

Some of the chiropodists sponsored a bill for a separate licensing board, but their desires, and similar attempts by naturopathic groups, failed to receive legislative approval.

A.B. 326 was introduced to meet the need for more nurses in California hospitals during the Duration. Governor Earl Warren gave his approval on March 18th. California nurse needs also receive comment in this number of CALIFORNIA AND WESTERN MEDICINE, in the department of the Committee on Hospitals. Members are urged to scan the suggestions there made. (See page 376.)

The attempt of the osteopaths to make osteopathic practitioners eligible for the position of Director of the State Board of Public Health did not meet with success.

The reconstituted California State Guard which, under a previous State administration, possessed in one division an osteopathic personnel, must now have a medical set-up that will conform to United States Army standards.

Every member of the California Medical Association should take the time to glance over the detailed report. It is refreshing to know that this year's record is so favorable to the best interests of the public health.

ON FEDERAL CHILDREN'S BUREAU PLAN OF MATERNITY AND INFANT CARE FOR WIVES AND INFANTS OF MEN IN THE ARMED FORCES

Circular No. 13 of Children's Bureau of the United States Department of Labor.—Under date of March 29, 1943, the United States Department of Labor through its Children's Bureau issued Information Circular No. 13, dealing with instructions to State health agencies [State Health Departments] with regard to plans and financial reports related to Emergency Appropriations for Maternity and Infant Care.

The circular states that the First Deficiency Appropriation Act, 1943, was approved March 18, 1943, making available an appropriation of $1,200,000.00, *"for grants to States . . . to provide, in addition to similar services otherwise available, medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the United States of the fourth, fifth, sixth, or seventh grades, under allotments by the Secretary of Labor and plans developed and administered by State health agencies and approved by the Chief of the Children's Bureau."*

With the objective above cited, namely, to provide that the health and lives of wives and infant children of enlisted men in the Armed Forces shall be conserved in so far as may be humanely possible,—while the husbands and fathers are at the front in defense of our Country,—no one, least of all the members of the medical profession, who from time immemorial have cared for their fellow humans, wishes to take exception. With their fellow citizens, physicians gladly share and accept this responsibility.

In what is here stated, the above objective is not under discussion. However, the methods of procedure proposed by the Federal agencies in Washington, D. C., to carry on this activity, may not be necessarily one hundred per cent perfect, any more than are a host of directives and promulgations which in the past on a multitude of matters affecting the public welfare, have come from the constituted federal agencies there located. That having been said, we can now proceed with further comment.

* * *

Newspaper Comment.—On May 3, 1943, the following statement appeared in the Pasadena *Post:*

Provision for wives and infants of men in the Armed Forces of the United States to receive special medical care, nursing, and hospitalization at the cost of the United States Government, is included in a new bill just adopted by the Congress, California Congressman Carl Hinshaw announced last night. . . .

Fund Set Up.—Under this new act the government has set up a fund to be allocated to the various states for the aid of wives and children of the men now fighting for this country.

California's share is said to amount to $37,500 and will be administered by the State Health Department through the various county health departments.

* * *

C.M.A. Appointed a Special Liaison Committee.—Turning now from all the above, it may be stated that the California Medical Association, in common with other constituent state medical associations, has given this important subject its earnest consideration. Council Chairman Philip K. Gilman appointed a special committee to study the proposed administrative plan. Personnel of the two groups, one for the northern and the other for the southern section of California, follows:

Special C.M.A. Committee on Medical and Hospital Care for Wives and Children of Enlisted Military Personnel

(Liaison Committee with California State Board of Public Health).

General Chairman of the two groups: (a) Northern; (b) Southern,—Dr. Karl L. Schaupp, San Francisco.

(a) *Northern Subdivision:*

Karl L. Schaupp, M.D., Chairman, San Francisco;
Lawrence Jacobus, M.D., Oakland;
George D. Barnett, M.D., Stanford University;
Mast Wolfson, M.D., Monterey;
John W. Sherrick, M.D., Oakland.

(b) *Southern Subdivision:*

Donald G. Tollefson, M.D., Chairman, Los Angeles;
William B. Thompson, M.D., Los Angeles;
B. O. Raulston, M.D., Los Angeles;
Charles G. Curtis, M.D., Brea;
Sam J. McClendon, M.D., San Diego.

* * *

Children's Bureau Circular No. 13 of March 29, 1943.—To furnish a proper background, it may be well to start somewhere at the beginning and present some excerpts from the thirteen page circular No. 13, referred to above. Quotations follow:

(3) *Methods and Policies of Authorizations for Payment of Services.*

. . . Initial authorization for hospital maternity care should not be for more than 14 days, and a minimum stay of 10 days postpartum should be arranged if at all feasible, in any acceptable hospital in the community.

(9) *Payments for Medical Care.*

The plan must include the rates of payment for the medical services provided at clinics or by private physicians under the plan. (The method of payment recommended in this section will be studied by the Children's Bureau with the coöperation of the States [State Boards of Health] and the Children's Bureau advisory committees during the next few months with a view to determining necessary modifications.)

(a) *Maternity Care.*

. . . *An inclusive rate* [Italics by Editor] for complete medical services during the prenatal period, labor, and the puerperium should be established by each State health agency on a State-wide basis. *These services should include* at least five prenatal examinations, care of complications, obstetric operations, postpartum care and postpartum examination approximately 6 weeks after delivery, and routine blood tests for syphilis, hemoglobin determinations, and urinalyses.

For care by general practitioners, inclusive rates have averaged $35 per case in the various States, or if prenatal care was provided in a prenatal clinic an average of $25 is usually paid for medical care during labor (at home or in an approved hospital) and postpartum care and examination approximately 6 weeks after delivery.

As the need arises, fee schedules for nonobstetric surgery and *specialized consultant services during pregnancy,* or within 6 weeks postpartum should be considered by the State health agency in conference with a technical advisory committee selected and appointed by the State health agency. These fee schedules should be submitted to the Children's Bureau [Washington, D. C.] for approval.

(b) *Health Supervision and Medical Care for Infants.*

Where health supervision or medical care for infants is provided in hospital out-patient departments or other clinics or conferences not maintained by official health agencies, arrangements may be needed for reimbursement on a cost basis for the services rendered in those clinics or conferences.

Medical care for sick infants requiring three visits or more by a private physician should be financed on a case basis, such as: $10.00 for home and hospital medical care during the first week of illness and $5.00 for home, office, and hospital medical care for succeeding weeks, with a minimum of three visits per week and for periods not longer than 3 weeks. . . .

Rates of payment for medical services rendered by pediatricians who are certified by the American Board of Pediatrics or assistant consultants who have had one or more years of graduate training in pediatrics in an approved residency may be approximately one-fourth to one-third higher than the rates of payment for services rendered by physicians who have not had such additional graduate training and experience.

* * *

Allocations to States under Initial Appropriation.—On page 12 of Circular No. 13 are given the tentative allocations to be granted to the different States to aid in carrying on this maternal and infant care, under the initial appropriation of $1,200,000.00. (It is proposed that hereafter the annual appropriation shall be $6,000,000.00. If that plan is put in operation, then in case allocations to States remain in the same proportion, California would receive six times the initial appropriation of $37,500.00, or $225,000.00. Kentucky, in similar wise, a like amount, and Missouri $460,650.00!) The listing of allocation for some of the Pacific States is followed by those of two commonwealths in the Middlewest (Kentucky and Missouri):

TABLE 1.—Conditional apportionment of $1,200,000.00 for medical and hospital obstetric and pediatric care for the wives and infants of men in military service (Fund E); distribution based on requests from the States for fourth quarter 1943 and consideration of authorizations already made under approved plans.

State	*Amount*
Arizona	$ 7,500
California	37,500
Idaho	10,000
Montana	10,000
New Mexico	25,000
Oregon	10,000
Utah	39,000
Washington	24,000
Kentucky	37,500
Missouri	76,925

* * *

Michigan State Medical Society is Interested.—The Michigan State Medical Society, in a circular letter of May 3, to secretaries of State Medical Societies, on the subject of medical care for wives and infants of enlisted men, stated:

1. American Medical Association federal legislative bulletins Nos. 25 and 26 outlined the amendment to the U. S. First Deficiency Appropriation making available to the U. S. Children's Bureau $1,200,000 for grants to States to provide medical, nursing and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the fourth, fifth, sixth and seventh grades.

A proposed program for this medical care, under Federal-State supervision, has been submitted to the Michigan State Medical Society by the Bureau of Maternal and Child Health of the Michigan Department of Health. . . .

Will you please advise us if your Society recently has approved a plan for such medical care based on HR-1975, the U. S. Appropriation Bill which became effective March 18, 1943?

* * *

Special Leaflet of the U. S. Children's Bureau.—The Children's Bureau of the U. S. Department of Labor is distributing a preliminary six-page folder leaflet in which additional information is given concerning the general plan in relation to State agencies:

How the Plan Works

The funds will be used by the Children's Bureau of the United States Department of Labor for grants to State health departments, including those of Alaska, Hawaii, Puerto Rico, and the District of Columbia, to provide medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces.

State health departments undertaking to provide these services submit their plans to the Children's Bureau with a request for funds. After the Bureau approves a State plan certification for payment is made to the Treasury Department, and the money is forwarded to the State. The funds are used to pay doctors, nurses, hospitals, and clinics for services previously authorized by the State health department.

Where to Write for Information

For information about the program—
If there is no doctor within reach—
If you do not know where to get an application form—

Write to Your
Director of Maternal and Child Health,
State Health Department
(City)(State).....

Other Details Concerning the Children's Bureau Plan.—To complete the outline of contemplated procedures, additional quotations from the six-page folder follow:

Maternity and Infant Care for
Wives and Infants of Men in the Armed Forces

[Army, Navy, Marine Corps, Coast Guard]

Maternity care for wives of men of certain grades in military service and medical and nursing care for their babies can now be provided without cost to the family through State health departments under plans approved by the Children's Bureau. Funds for the next few months have already been voted by Congress in a bill signed by the President on March 18, 1943.

Under this plan a pregnant woman may receive prenatal care from a qualified doctor of medicine in a clinic or at this office. At childbirth, whether she stays at home or goes to a hospital, she and her baby may receive medical and nursing care. Complete maternity care may be provided, including a final physical examination 6 weeks after the baby is born, and the baby may receive medical care during the first year of life. . . .

Available through medical or hospital facilities of the Army or Navy or by or through official State or local health agencies. How long the wife has lived in the State does not matter. How much money the family has does not matter. Race or color does not matter.

How to Apply

Forms for requesting care are made available by the State health departments through local health and welfare agencies, local American Red Cross chapters, prenatal clinics, military posts, and through local practicing doctors of medicine. . . .

What Services the Patient Can Expect

In States providing these services:

Complete medical service, for maternity patients during the prenatal period, childbirth, and 6 weeks thereafter—including care of complications, operations, postpartum examination—and to the newborn infant. . . .

Hospital care in wards or at ward rates, for maternity patients and infants. . . .

* * *

Tentative Studies of C.M.A. Committee.—The two C.M.A. committees met with representatives of the California State Board of Health and the U. S. Children's Bureau and outlined in some detail why they objected to having a *below-cost* fee schedule from Washington, D. C. (supposedly at $35.00 fee to cover prenatal, confinement, and postpartum care as outlined in the excerpts above given).

In a letter of June 2nd, sent for the information of C.M.A. delegates who would be in attendance at the session of the A.M.A. House of Delegates, in Chicago, commencing on June 7th, the following statements were made:

In regard to the above, it may be stated that the Northern California Committee, in opposing a $35.00 flat fee, stood out for a $50.00 fee for the attending physician, with additional pay up to $50.00, for consultation and aid in complicated cases. Also, in any literature to be distributed in California, the Committee insisted the Government must prominently mention the fact that the *governmental aid did not cover the full costs*, the service being made possible only through the generous contributions and support of members of the medical profession.

The Southern California Sub-Committee favored a $75.00 fee.

In Portland at the Pacific States Medical Executives' Conference, the representatives of the Oregon State Medical Association stated the members of their Association would prefer to do the obstetric work without pay, in preference to a governmental fee that did not cover costs of such professional service. (It is said that Michigan has taken a somewhat similar position.)

The Government may establish the fee its Bureau officials approve. The Oregon colleagues felt that *any governmental fee so established should not be paid to the attending physicians direct, but to the patients; the patients in turn to choose their own physicians and make such arrangements as to fees as might be mutually agreeable.* (For Pacific Conference resolutions, see page 375.)

In this way, it was hoped to avoid the establishment of a *below-cost* fee schedule that would be flaunted at the medical profession for years to come as being a "fair fee" that the profession had accepted.

It was also felt that the profession had a right to call attention to the fact that all war production work was on a cost plus basis. That professional services by physicians, comprehending hundreds of thousands of dollars had been given by Selective Service and other examiners. Also, that there should be a limit to the gratuitous service demanded of physicians. It was believed, by calling attention to the various factors, the public would be informed concerning the real issues involved, etc.

In connection with the proposed grants-in-aid through the Federal Children's Bureau (to constituted State Agencies such as the State Board of Health) to provide certain types of medical care, it may not be out of place to refer to an experience in 1927-1928.

At that time the Crippled Children's work came to the front, and the decision reached by the California State Board of Public Health was that the federal money would not be accepted if it was mandatory to accept a fee table previously set up in Washington for professional services that had been rendered.

The California State Board of Public Health stated it would be most happy to aid in the proper care of the crippled children of the State, and to receive federal monies in connection therewith; but the State Health Board would insist upon the right to set up its own fee table, in harmony with established standards in California, and determine to whom, for what and when such payments would be made.

In principle, the issue in connection with maternity aid is somewhat similar.

* * *

Resolution of the Pacific States Medical Executives' Conference.—To complete the picture, so far as relates to its status at the time of this writing, the resolution of the Pacific States Medical Executives' Conference may be appended:

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE

Resolutions adopted on May 29-30, 1943, at the 5th Annual Session in Portland, Philip K. Gilman, California, presiding

The Reference Committee (George E. Henton, Oregon, Chairman, Homer D. Dudley, Washington, and George H. Kress, California) recommends the adoption of the following resolutions:

Resolution No. 1

Resolved, That approval be expressed of federal assistance to the wives and children of service men as outlined in the plan under consideration by the Federal Children's Bureau; provided however, that the constituent state medical associations which are members of the Pacific States Medical Executives' Conference be requested to consider carefully the merits of the procedure proposed by the Oregon State Medical Society, wherein any allocations for professional services agreed upon as compensation for obstetric work involved shall be given to the wives of enlisted men; such patients then to secure the services of physicians as they themselves deem proper, the fee for professional services to be decided by mutual agreement between the patients and the attending physicians; and

Resolved, That the Conference Secretary send outlines of the Oregon plan to the constituent state associations; and further

Resolved, The suggestion be made that a special committee composed of representatives of the Pacific States medical associations be brought into being, if possible, to further consider the above Oregon plan.

* * *

To Summarize.—If the issues involved were not so important, both for present-day and future medical practice, the space for the above citations would not have been given.

Even though the plan be inaugurated when our Country is at war, it is nevertheless important that proper understanding should be had by physicians concerning the implications in the proposed maternity care plans, as tentatively outlined by the U. S. Children's Bureau.

Every component county society,—some in wartime production areas, more than the others—has real responsibilities in relation to the proposed work. The C.M.A. Council will meet on June 19-20 next. County Societies and individual members of the California Medical Association are invited to promptly send their suggestions and advices to the C.M.A. Council, 450 Sutter, San Francisco.

EDITORIAL COMMENT†

COLLATERAL PANIMMUNITY IN TUBERCULOSIS

In order to explain accumulated data from a ten-year study of the collateral immunity in experimental tuberculosis, Ascoli and his colleagues of the University of Milan introduced the term "anachoresis." This term refers to: (a) the apparent elective mobilization of nontubercular bacteria (and viruses) in acute tuberculous nodules, and (b) their subsequent destruction by the local inflammatory tissues. Thus considered, the local tuberculous nodule becomes a universal "cleanser" for the body as a whole, a hypothetical panimmunity mechanism of major clinical interest.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Data suggesting this anachoretic theory have been recently summarized in American literature.[1] As a typical example of such data, a single tuberculous nodule was found in the spleen of a rabbit previously inoculated with attenuated bovine tubercle bacilli. This nodule contained both viable tubercle bacilli and Pasteurella caniculeseptica, which latter organism was demonstrable in no other tissue of the tuberculous animal. Numerous data of this type pointed to the conclusion that "microörganisms of all types are drawn to" the tuberculous nodule due to the process of "anachoresis." Similar anachoretic mobilization can be demonstrated with other local inflammatory lesions. For example, Robinson and Boling[2] have described an "anachoretic pulpitis," due to the elective localization of naturally acquired infections in the irritated pulps of teeth.

Destruction of locally mobilized microörganisms within the anachoretic nodules was noted in calves previously inoculated subcutaneously with B.C.G. These calves were resistant to experimental pasteurella infections, which proved fatal to non-vaccinated calves.[3] A similar anachoretic immunity was deduced from the lowered morbidity and mortality to experimental foot-and-mouth disease[4] and B. abortus infections in B.C.G. vaccinated guinea pigs.[5] Vaccinated guinea pigs when deprived of their tuberculous nodules lost this collateral panimmunity. Transplantation of the excised nodules into normal guinea pigs immediately increases their resistance to B. abortus and other infections.[6] Extirpation of the primary nodule is also followed by an immediate loss of required resistance to tuberculosis.[7] Ascoli believes that a large part of the acquired resistance to tuberculosis is thus attributable to the "cleanser" effect of the primary tuberculous nodule.

Ascoli and his associates have subsequently repeated these extirpation and transplantation experiments on calves. In one experiment, a four-months'-old calf was inoculated subcutaneously in the dewlap with a viable tuberculosis vaccine with the resulting formation of two hard, painless nodules, each about one inch in diameter. Nine days later the two nodules were removed and each transplanted into the dewlap of a normal calf. As soon as the surgical incisions had healed, the two recipients, together with the doner, and a normal control were each injected intravenously with 0.1 mg. doses of highly virulent bovine tubercle bacilli. Five months later, the four calves were slaughtered. Miliary tuberculosis was demonstrated in the lungs and thoracic lymph nodes of the control calf. In the calf from which the vaccinal nodules had been removed, there was an enlargement of the thoracic and pharyngeal lymph nodes in which, however, specific tuberculous lesions could not be demonstrated. In the two calves receiving the tuberculous nodule, the thoracic organs were wholly free from tuberculous manifestations. Total thoracic resistance to intravenously injected virulent tubercle bacilli, therefore, was apparently effected by the anachoretic ingraft in the two normal calves.

Anachoretic phenomena also apparently play a rôle in experimental syphilis. Brown and Pearce[8] found an aggravation of experimental syphilis in rabbits following removal of the primary testicular lesion.

Evidence that a primary tuberculous, syphilitic, or other local inflammatory nodule may serve as effective panimmunity mechanism is, therefore, fairly conclusive. Ascoli's hypothesis that "microörganisms of all kinds are drawn to" such inflammatory foci and are there destroyed by the local cellular defenses, however, is still controversial. It would seem to be equally plausible to assume that the local inflammatory nodules give off non-specific hormones (or necrotic products) stimulating (or activating) cytological defenses in other parts of the body. This second explanation, which is now under investigation in American laboratories, would be of wide practical clinical interest.

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ORIGINAL ARTICLES

Scientific and General

CALIFORNIA MEDICINE: IN BRIEF REVIEW*

ADDRESS OF THE PRESIDENT

WILLIAM R. MOLONY, SR., M. D.
Los Angeles

IT is the privilege of the President of this Association to prepare and read an address at the annual meetings; each in turn voicing impressions gained from a busy life of practice; and all of these subjects have been worth while. Many have been concerned with Association affairs and suggested improvements; others have discussed new laws and economic changes; while some have delved into ancient history and the classics, and still others have reviewed medical accomplishments.

I am neither a prophet nor a philosopher. not very good at regulating the affairs of others, find no fault with Association affairs (which, by the way, I think are in excellent shape), and I cannot forecast the future, which to me is a closed book and an uncharted course. To evaluate our accomplishments and to appreciate our benefits we should know something of our background. It is not my purpose to write a history of medicine in California, but rather to move rapidly along, giving here and there enough of the historical events which have marked the cavalcade of medicine in California.

I have an abiding affection and devotion to medicine—which includes that group of men and women who, throughout the ages, have unselfishly given of themselves to the cause of healing, whose every thought and act have been for the good and well-being of the patient; the safeguarding of their fellows from the ravages of pestilence and disease. These are they who zealously safeguarded the honor and integrity of their sacred calling.

A young doctor upon his graduation was admonished in this wise: "Whether or not your career will be great or ordinary, depends very much upon yourself. In practice you will be among human beings and will have a great opportunity for service. The rewards you will receive will not be monetary, but spiritual. The monument you will have in that far distant day when you leave this world will not be of stone. It will be something, rather, in the memory of the many you have served. They will remember you for what you did. and be grateful.

"The reason, of course, is because of the peculiar and extraordinary relation that exists between the physician and his patient. You will see people as others rarely see them; when they are ill and dispairing, and need help desperately; you will not only be the healer of bodies but will be the healer of souls.

"You will find the psychic side of your ministration equal to the physical, often more so. It can be said with Robert Louis Stevenson that no calling in the world has a higher opportunity for human service than that of the true physician. There are all kinds of doctors; some are mediocre, but when you meet a good one, a great humanist as well as a great physician, how his light does shine."

I was born in Los Angeles in 1879, at which time this city was a pueblo of less than 10,000 population. Here it was that I received my academic and medical education.

The cavalcade of medicine in California, beginning with the Mission period, is an epic of achievement. The romance and tradition of this Golden State, and my association with the early pioneers who built so well, imbued in me the spirit of the West and my love of California. We may well be proud of the accomplishments of medicine, and to that group of courageous men who shaped our destiny, we are grateful.

As the pages of medicine unfolded and I was launched upon the, (to me) uncharted sea of practice, the activity and glamour of medicine centered in San Francisco. The rapid growth of the state, with its improved travel facilities, served to widen this influence, and the benefits of medicine, once confined to the larger cities, were made available to the smaller communities.

BEGINNINGS OF MEDICINE IN CALIFORNIA

The story of the beginning and progress of medicine in California, therefore, is fascinating and thrilling. Its unfolding is replete with the stories of the courageous men and women who never faltered; who, in the traditions of the true physician, cared for the sick and needy, promoted better health and educated their successors. Then, as now, the Doctor, the Church, and the State joined hands for the relief of suffering, the saving of souls and the good of humanity. With the exception of a temporary visit and a sporadic attempt on the part of the Spanish, Portugese, English, and Russian sailing masters, the civilization and development of California began with the Franciscan Missionaries who accompanied the first Spanish expedition to San Diego.

The zeal of Father Junipero Serra for the salvation of souls led him and his associates to endure great hardships and to persevere until success crowned their mission.

With Serra on his journey from San Diego to Monterey, the site of the second mission, was Dr. Pedro Prat, the first surgeon in California. The Franciscan Fathers year by year established a chain of mission, 21 in all, extending throughout the length of California, from San Diego on the South to Sonoma on the North. They brought to the Indians a practical application of the trades, arts, and sciences.

* Address of the President. Read before the General Meeting at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

These missions were spaced along the El Camino Real about a day's journey from each other, and were designed for the education and the spiritual care of the Indians. The saintly Serra, when he began his California mission, was 58 years old; and he traveled on foot, time and time again, from Mission to Mission during the years of his administration.

Beginning with Dr. Pedro Prat in 1769, and ending with the Spanish régime in 1824, nine Doctors of Medicine served as Surgeon General at Monterey. Outside of an occasional call from a surgeon with a visiting warship, the only medical men in the province were these doctors.

The Padres possessed considerable medical knowledge, gave the necessary medical and nursing care to their people, were capable of doing minor surgery and, if need be, performed more serious and complicated operations.

The Mexican period was ushered in by the revolution of 1822. Up to this time, the trend of civilization had been upward. Mexico declared herself independent of Spain, and then followed a period of decadence; the Missions were seized, secularized and desecrated.

The Spanish régime of more than 50 years was marked by a dearth of doctors, drugs, and diseases. The Surgeon General of the province, with the help of the missionary Fathers and a partera (mid-wife), was able to care for the people in this vast domain.

POST-SPANISH ERA

With the coming of the "Gringo," an array of "winged and wan" diseases followed: epidemics of small-pox, measles, scarlet fever and cholera, with an increase in tuberculosis and syphilis.

The pueblos and ranchos were widely scattered, so that it was not possible for one surgeon to care for all. Gradually, the practice of hospital stewards, drug clerks, phlebotomists, barbers, scouts and trappers assumed the rôle of the "Doctor" in their respective communities.

Even in the American period there were many persons of this type, and some occupied such positions of prominence that considerable difficulty was encountered when the first medical society insisted that its members be graduate M.D.'s.

Some charlatans flourished. Meeks of Monterey, Sparks of Santa Barbara, and William Money of Los Angeles were shining examples. A scattering of men of education with a background in medicine contributed not a little to the needs of their communities, such as "Dr." Richard Den, and "Dr." De La Cuesta of Santa Barbara, and John Marsh.

In 1828 smallpox was epidemic. One James Pattie, not an M.D., arrived in San Diego bringing with him a supply of vaccine. He traveled as far north as Bodega, vaccinating in all, so it is said, more than 22,000 persons. Thus began the practice of preventive medicine and public health in California.

In the north, although Mission Dolores and the Presidio date from 1776, the medical history of the San Francisco peninsula did not begin until about 1844-1845. In this year came Dr. John Townsend who is said to have rocked the cradle of medicine in San Francisco.

The spirit of adventure, the lure of the West and the discovery of gold were the magnets that drew a vast multitude to California. In this rush came the men who were to make medical history.

At the close of the Mexican period there were but few doctors with a sound medical training. Most of the pueblos and villages were dependent on men with but a smattering of medical knowledge. Cephas L. Bard of Ventura, a noted pioneer physician relates, that everyone was a self-constituted physician, according to the old provincial adage:—

"De medico, poeta y loco
Todos tenemos in poco."

Or freely translated, "Of medicine, poetry and insanity we all possess a little."

NORTHERN CALIFORNIA

San Francisco was just emerging from the village of Yerba Buena when the gold excitement began. With others went the doctors to the mines, not to practice, but to seek their fortunes. As the mining craze subsided, the doctors, old and new, returned to their vocations.

Sacramento, at that time, was the center of mining activity and the medical center of the Golden Age. In 1850 more than fifty doctors signed the roster of the Medico-Chirurgical Society.

Out of this motley crowd of physicians attracted to the State during the gold excitement, a goodly number remained; and to these, medicine owes a debt of gratitude. Many in their home communities had been skillful and successful practitioners. Of these pioneer doctors, risking the dangers of the journey, it has been said that only the brave attempted it and only the strong survived. These were superior to their fellows. The great hospitals and medical schools, our medical societies, postgraduate courses and medical journals are all monuments to these pioneer men of medicine.

One such pioneer was Elias S. Cooper, the founder, in 1858, of the Medical Department of the University of the Pacific, which, after a troubled existence was succeeded by the Cooper Medical College, to become in 1908, the School of Medicine of Stanford University.

Another was Hugh H. Toland, founder, in 1864, of the Toland Medical College. He occupied a place in the medical world that has seldom been equaled. He was a sponsor and benefactor to many medical and civic activities. Through his efforts and generosity the Toland Medical College, in 1873, became the Medical School of the University of California.

Henry Gibbon, Sr., inaugurated the first course of medical lectures in California, and was fore-

most in the promotion of medical education. He left a heritage which has shone brilliantly in his descendants. Dr. Beverly Cole, a picturesque and forceful character, served as Dean of the Toland Medical College and the University of California.

Probably the greatest genius of the period was Levi Cooper Lane who, in 1860, joined his uncle Dr. Elias Cooper. He possessed more college degrees than any other doctor in California. He was a master of six languages and a brilliant man of parts. In time he accomplished that in which his uncle had failed—the founding of a successful medical school, teaching hospital and medical library, the latter of which still bears his name.

The impetus given medicine by these unselfish pioneers generated in California a spirit of progress which grew stronger through the years, and wrought accomplishments that compelled the admiration of the medical world.

The southern part of the state, far removed from the excitement and lure of the gold rush, was but sparsely inhabited. Los Angeles, San Diego and Santa Barbara were small pueblos. The great ranchos extending from the Tehachapis to San Diego were the principal assets.

SOUTHERN CALIFORNIA

In 1850 while San Francisco was teeming with a population of 100,000; less than 2,000 resided in Los Angeles. However, it was in this year that the physicians of Los Angeles organized the first medical society in California.

Practice was difficult, travel was by horseback and stage. Development of the great Southwest was very rapid after the coming of the railroads, which brought in a large number of people.

The pioneer physicians were joined by others attracted by adventure, climate, and the spirit of the West. Medical progress was slow, hospital facilities meagre, the only hospital being the Sisters which was the center of medical activity.

In the early eighties, Dr. Joseph P. Widney, in an address to the Medical Society of the State of California (former name of the California Medical Association), concerning medical education, stated that it was important for every practitioner of the healing art to be an educated man, and to be trained in the underlying principles of disease, its causation, its phenomena, and its pathology. This great man envisioned the need for medical education in the South; and in 1885 he founded the College of Medicine which, through the years, has been eminently successful, and has been the stimulus for the continued activity and development of medicine in Southern California. This college has the distinguished honor of having had four of its faculty, and six of its alumni, elected to the presidency of the California Medical Association.

On the faculty were such men as Henry C. Brainerd, pioneer neuropsychiatrist, who succeeded Dr. Widney as Dean; and Dr. Joseph Kurtz, a picturesque character, a great teacher and a pioneer orthopedist.

Granville MacGowan, a genial gentleman of culture, also was a typical genito-urinary specialist of his period, who throughout his busy life exerted a marked influence for the good of medicine and the community.

A dynamic personality and the outstanding specialist in eye, ear, nose, and throat was H. Bert. Ellis. He was a potent force in the State Medical Society and the American Medical Association.

George W. Lasher, noted surgeon and teacher, and his close friend, F. T. Bicknell, exemplified the high standards of honesty and ethics.

The arrival in the nineties of Francis and John R. Haynes, marked the modern concept of surgery and internal medicine. To Stanley Black we owe our modern practice of pathology.

Norman Bridge stimulated interest in the management of tuberculosis, and bequeathed his fortune to further medical education.

The practical and sound conception of public health, now in force, had its origin in the energy and foresight of Dr. L. M. Powers. He pioneered in pure water, pure milk, and effective quarantine.

This narrative would not be complete without a word of tribute to Dr. Walter Lindley—a man devoted to the best in medicine. The "Southern California Practitioner," the California Hospital and the College of Medicine bear witness to his zeal. In addition, through his tremendous influence in the political and business world, medicine gained much.

To Walter Jarvis Barlow the people of Southern California owe a debt of gratitude. Through his love of humanity, his interest in medical education and civic progress, he founded the Barlow Sanitarium, a prototype of all similar institutions that were to follow.

Dr. Barlow was Dean of the Medical School of the University of Southern California, and gave to the medical profession of the great Southwest a medical library which bears his name, and which is now one of the activities supported by the Los Angeles County Medical Association.

To our contemporaries who through the years, in season and out, have unselfishly devoted themselves to medicine and this organization, I wish to express my appreciation. The county societies and the State Association have gained much from their wisdom and experience. Their presence has been, and is a stimulating influence upon those who follow.

It would be a pleasure to call the roll of this distinguished group, but time does not permit. However, there is one to whom I wish to pay special tribute. A man of outstanding accomplishment who, for forty years, has devoted his talents and his energy to the interests of medicine and this Association. It was he who fostered the program for certified milk and the control of tuberculosis. Medical education, postgraduate work, and improved hospital service owe much to his interest and perseverance. His association with civic institutions and projects which were concerned with

medicine has been of great value. By pen and voice he has vigorously fought the enemies of scientific medicine. No man has given more than George H. Kress, my friend and yours.

RÔLE OF THE GENERAL PRACTITIONER

The strength of the profession lies in the general practitioner, the family doctor, if you will, the man who, through prosperity and depression, carried on and ministered to the sick and needy. From his devotion to medicine and education have come the great hospitals, clinics, colleges and medical societies.

Specialization in medicine has made for better service. It has been the means through which great advances have been made in medical practice. The specialist has an important place in our system of practice, and his contribution is of inestimable value. But let us not forget that in the general practitioner lies the strength of American medicine.

It is true that the well-trained, general practitioner can give competent care to 85 per cent of all sick people. These are the men who are available at all hours of the day and night regardless of weather or danger. They are the ones to whom the people turn when sickness comes, and who make the initial diagnosis and render the emergency treatment.

This class of practitioners needs the encouragement of the specialists, the hospitals, and the colleges. Such men must have opportunities for better training and experience. They certainly are not going to be helped very much by a curtailment of their hospital facilities.

It must not be forgotten that modern practice is impossible without hospital service. The doctor is licensed by the state to practice as a physician and surgeon. Hospital facilities are essential to his practice. If the bars are too high, it is possible that corrective legislation may be enacted.

The importance of the place in medicine for the general practitioner was recognized three years ago when the House of Delegates of the American Medical Association created a section on General Practice.

ENVIABLE RECORD OF THE MEDICAL PROFESSION

My association on the Board of Medical Examiners for nearly 30 years, in addition to other activities in the field of medicine, has brought me in contact with a multitude of doctors, young and old, of high and low degree, nearly all imbued with that high sense of integrity and loyalty that, from the time of Aesculapius, has characterized the true physician. Like the parasite, which takes all and gives nothing, is that other type of doctor, the despicable type who, false to the traditions, ideals, and ethics of his profession, has turned traitor and commercialized medicine. The frank advertiser is out in the open; he can be seen for what he is; but that hypocrite who, in the guise of respectability and legality, undermines his fellow physicians, merits our deepest contempt.

We are proud of the men and women in our profession who have fought the good fight, and who, through the passing years, have adhered to the time-honored principles of the American way of life.

American medicine may well be proud of its exalted position in World War II. For three years before Pearl Harbor, its resources were being mobilized, so, when the call came, it was ready. Members of the California Medical Association have responded to the needs of our Armed Forces to a degree that has depleted our ranks and caused some concern for the care of the civilians at home. This patriotic response was prompt, spontaneous, and without compulsion. No other class or profession has given so much to the success of this war.

THE FUTURE?

The most serious threat to the American way of practicing medicine is the formation of plans, by some of those in government, for changes in the system of medical care. For many years certain groups in this country, following in the footsteps of similar groups in European countries, have labored early and late to fasten their socialistic program of state medicine upon the people of the United States. Surrounded and permeated by a motley group of intellectuals, sociologists, Ph.D's., citizen "fixits" and well-meaning but misguided people, the Administration seems bent on the launching of an economic plan, an important part of which is the regulation of medical care according to plan, and the regimentation of the medical profession.

We are not unmindful that changes in our economic scheme of life are bound to follow at the conclusion of this war. From the beginning, American medicine has kept pace with the development of the country, has worked out its own problems, has cleaned its own house, raised the standards of education and practice to a degree beyond that of any other country. Regardless of creed or color, rich and poor alike have received the best of medical care.

Come what will, the men and women who have built American medicine through the last 100 years will not stop, but will continue to improve and progress under the free and competitive system of life.

1930 Wilshire Boulevard.

Knowledge of population trends enables us to foresee a rise in the number of persons requiring hospital care for mental disease because in future larger numbers will reach the ages at which mental disease is most apt to occur.—Frank G. Boudreau.

There are one and one-half times as many deaths from tuberculosis among men as among women. The preponderance of deaths among men is in the older age groups, the reverse is true among women.—Mary Dempsey. National Tuberculosis Association.

DERMATOLOGICAL EXPERIENCES IN A UNITED STATES NAVAL HOSPITAL*

Lt. Comdr. Frederick G. Novy, Jr.
MEDICAL CORPS, V(S) U. S N. R.

THIS article deals with specific dermatological experiences encountered at the United States Naval Hospital at Oakland. This is a large hospital, having many patients who have seen service in the South Pacific. Local medical problems among the Navy personnel in Northern California are, for the most part, taken care of by other hospitals. For this reason many problems as, for example, that of the venereal disease, are contrary to experience elsewhere.

At the present time there are two dermatologists, both members of the American Board of Dermatology and Syphilology, at the hospital. There is a special ward of fifty-five beds provided for the department. The ward has three treatment rooms, one of which is a continuous-flow tub. Besides taking care of the patients assigned to the ward, the department sees all patients presenting cutaneous diseases in consultation with other departments. All of the syphilis at the hospital is seen in consultation, and the antiluetic therapy is given by us. Superficial x-ray is given by the Department of Roentgenology under the direction of the Department of Dermatology. In addition to the work at the hospital, many cases are seen in consultation from near-by dispensaries and stations.

Certain observations regarding specific diseases have come to our attention during the past few months. To simplify discussion, they will be considered under the following headings.

DISEASES DUE TO ANIMAL PARASITES

So far there have been no large epidemics of these diseases which so frequently become a major medico-military problem. Scabies has not been seen with any greater incidence than is encountered in clinic practice. We have had good results with the use of a lotion made of equal parts of sapo mollis, isopropyl alcohol and benzl benzoate.

Of the pediculi group, the only one so far encountered has been pediculosis pubis. At times, there have been small epidemics from this parasite, when a draft has arrived from a ship that has been unable to properly launder its clothing and bedclothing. This problem has been handled with the use of 1-2000 mercury bichloride in equal parts of calamine lotion and alcohol. This is followed in two to four days with a 5 per cent acetic acid rinse.

Fleas have been a very minor problem. For the most part, the patients have become infected while on liberty to the nearby cities, which are famous for pulex irritans.

FUNGUS INFECTIONS

To date, we have had no rare or unusual tropical fungus infections, as, for example, tinea imbricata or Madura foot. The usual story of the infections that we have seen is that the men have gone to the tropics with a mild fungus infection present. Then, under poor hygenic conditions, together with heat and high humidity, there has been an acute severe exacerbation. Superimposed upon this there is frequently a pyogenic infection. Generalized "id" eruptions have been seen frequently following this chain of events. Many of these patients have been hospitalized in the tropics for long periods, and all types of therapy employed without avail. On the way home, with two to three weeks of sea travel, they improve rapidly, so that many are ready for duty on arrival. Therapy which has usually been efficacious here has been wet dressings of the usual type, until the acute phase of vesiculation and secondary infection are over. Then drying lotions or pastes are applied. Our experience with 2 per cent iodine crystals in benzol or xylol has been very gratifying. Dr. James[1] has recently amplified on this problem.

Tinea cruris seems to be nearly a universal complaint in the Navy. This condition almost always is exacerbated with tropical duty. Painting with 2 per cent iodine crystals in benzol or xylol, followed by talc powder, has given good results. Salicylic acid and benzoic acid in alcohol also has been beneficial.

Tinea corporis has been seen only a few times. None of the deep fungus infections have been encountered.

URTICARIA AND ANGIONEUROTIC EDEMA

For some unexplained reason these two related conditions have been seen in a higher incidence than is encountered in either clinic or private practice. Both of these, of course, have been of the chronic type. The incidence of foci of infection in these cases has not been unusually high. Some, however, have benefited with the removal of badly-infected tonsils.

Several of the cases of angioneurotic edema have been seen in patients with filariasis. It is known that one of the presenting symptoms of filariasis is urticaria and angioneurotic edema. After finding filaria in some of the first cases of angioneurotic edema, search for this parasite in following cases has frequently been positive.

IODODERMA

There have been three interesting cases of this condition. They were all in young men who had an acne type of skin, but not active acne until they went into action in the South Pacific. Then they had to sterilize their drinking water with tincture of iodine. This plus heat and poor sanitary conditions quickly led to a rather severe

* From the United States Naval Hospital, Oakland, California. The opinions or assertions contained therein are the private ones of the writer, and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

Read before the Section of Dermatology and Syphilology of the California Medical Association, Los Angeles, May 3, 1943.

pustular infection. This condition responded quickly to change of living conditions and climate.

CONTACT DERMATITIS

This problem is ever with us, and it is always interesting to attempt to ferret out the exciting agent. There have been two factors which we have seen in the Navy which are not common in civilian life. There have been several patients who are sensitive to the Navy blue woolen uniforms. The eruption appears on the extremities for the most part. This has been severe enough in some cases to recommend discharge. The other factor is that the dyes from the regular issue shoes cause a contact dermatitis which must be differentiated from fungus or pyogenic infections of the feet.

VENEREAL DISEASES

The low incidence of these diseases at the hospital has been most striking. No cases of the rarer venereal diseases granuloma inguinale and chancroid have been seen. There has been one case of lymphopathia venerum. The incidence of gonorrhea is low. This can be explained by the fact that the uncomplicated cases are treated at smaller medical units, mainly dispensaries and ships, and only those that have complications come to the hospital.

Syphilis also has a low incidence. A routine Kahn test is done on all patients that enter the hospital. Over seven thousand tests have been done in the last eight months, and only 1.83 per cent have been positive. Of this latter figure 0.6 per cent were false positives, leaving 1.23 per cent which actually syphilis.

Very few cases of early syphilis have been seen. This again could be accounted for by the fact that these patients are seen at other medical stations. Another factor is that the personnel who have been in action in the South Pacific have not had the opportunity for contracting the disease.

It is interesting to note in this connection the recent editorial in the *Journal of the American Medical Association*,[2] which states that there was extremely low incidence of syphilis in the Army in the last half of the past year as against a rapid rise in the incidence soon after the draft law went into effect.

We have been employing in early syphilis a semi-intensive form of therapy. It consists of three injections of mapharsen 0.06 gms. weekly, and one injection of 0.13 gms. of Bismuth sub salicylate.

FALSE POSITIVE SEROLOGICAL REACTIONS

A number of these reactions have been encountered. Some of the slightly positive come from acute upper respiratory infections. Infectious mononucleousis is another bad offender. There have been two cases of strongly positive reactions from this disease. Other causes of false positive reactions are those appearing after routine immunization injections. We have also seen a few connected with filariasis.

Malaria has produced the largest number of false positives. In six to eight patients the reaction was strongly positive. On following these patients, the reaction slowly diminishes and finally becomes negative. This sometimes takes two to three months. It is important to note this, since a great mistake could easily be made if antiluetic therapy were started with only the finding of a positive serology.

COMMENT

In addition to the above, we have had the usual incidence of the common and rarer cutaneous diseases that would be seen in a civilian service of this size. It appears then that, so far, dermatological problems in the Navy are very similar to our previous experience in private and clinic practice. In the very near future, however, truly unusual problems from the tropics may arise.

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MENTAL ILLNESS FOLLOWING PREGNANCY*

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WHILE mental illness following pregnancy is an unusual incident in the practice of the average obstetrician or general practitioner, it is a constant problem to the psychiatrist. Before the development of shock therapy the outlook was usually unfavorable, and the patients which recovered were necessarily hospitalized for many months. In the author's experience the proper use of shock therapy, in these cases, has been a valuable procedure, not only in reducing the period of hospitalization, but in markedly increasing the percentage of recovery.

FREQUENCY OF PSYCHOSES IN PREGNANCY

It has been shown in various statistical studies that a psychosis results in one out of every 400 to 1000[1] pregnancies, and also that about 5 to 10 per cent of the psychoses in women follow pregnancy. While it is generally felt that there should be no separate classification of puerperal psychosis, and that the illness should be considered as a manifestation of schizophrenic, manic-depressive psychosis or a toxic-exhaustive psychosis, the author cannot accept this viewpoint without certain reservations. Often the psychoses in this group are not easy to define in terms of other psychoses, as they tend to be a separate entity. This feature has been noted by others. Strecker

* Chairman's Address.—Read before the Section on Neuropsychiatry, at the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

and Ebaugh[2] found a severely disturbed sensorium in 77 per cent, and hallucinosis in 30 per cent of their cases diagnosed as manic-depressive. They also noted a great frequency of manic-depressive features in their cases diagnosed as dementia praecox. The variability of puerperal psychoses was shown by Karnosh and Hope,[3] who compared the incidence of childbirth psychoses to the number of births and to all types of psychoses which developed over a ten-year period in the same registration area, and could demonstrate no fixed constancy of puerperal psychoses as compared to the birth rate or to the total psychotic population. Consequently, it would seem that there are other factors involved besides the constitutional predisposition of the patient to develop a certain type of psychosis under severe psysiological changes. What these factors are the author is not required to state. Toxic, endocrine and emotional factors have all been implicated by various authors.

AUTHOR'S SERIES

The author has had under his observation 11 patients who developed a psychosis after pregnancy since the advent of shock therapy. Of these, nine would by the standard classification have a schizophrenic type of response, while two were manic-depressive in nature. No cases of the so-called toxic-exhaustive group were observed. Incongruity of behavior, stereotypy, silliness, impulsiveness, catatonia, incoherence and blocking of speech, delusions, ideas of reference, and hallucinations were in evidence. In the depressed cases, poverty of thought, feelings of inadequacy, ideas of self-accusation and self-deprecation, strong suicidal tendencies were considered to be significant. No case was included in which the mental symptoms did not develop within three weeks after delivery. Patients with a "dementia praecox reaction" were given insulin shock by preference, those with depressions received convulsive shock therapy. Convulsive therapy was also used in the cases of dementia praecox type which did not show an adequate response to a full course of insulin shock therapy.

REPORT OF CASES

Case 1.—Mrs. S. J., aged 25 years, was first seen July 30, 1939. A week after her second baby was born she had become acutely disturbed. She had been excited and negativistic at first, rapidly becoming delusional and hallucinatory. She received a full course of insulin shock therapy without experiencing complete remission, but after a short period of routine care she was discharged on November 22, 1939. She was somewhat unstable emotionally and psychoneurotic for a time, but gradually improved and at present seems quite well. She had apparently been depressed for several months following the birth of the first child two years before.

* * *

Case 2.—Mrs. M. G., a primipara aged 26, had no difficulty until the day of her delivery, July 7, 1938, when she became confused and fearful. This disturbance subsided; but ten days later she became seclusive, had blocking of speech, and was not sure the baby was hers. She received a full course of insulin shock therapy, following which she was discharged. However, she relapsed, returned to the sanitarium and was given four metrazol convulsions. She had a complete remission, was discharged December 23, 1938, and has remained well since.

* * *

Case 3.—Mrs. A. H., aged 29, was first seen on August 29, 1939, when her second child was 13 months old. About 2 weeks after this child's birth, she had developed the fear that she would be unable to care for it. She progressively became more depressed, developed insomnia, anorexia, and was quite restless. She became convinced that nothing could be done for her, and was institutionalized only after three attempts at suicide. In the sanitarium she gradually became more disturbed and developed somatic delusions. Finally, consent from the Christian Scientist husband was obtained, and the patient was given twelve metrazol convulsions and made a complete recovery. She was discharged December 29, and has remained well.

* * *

Case 4.—Mrs. F. L., aged 26, was first seen December 21, 1939, after the birth of her third child. During her pregnancy she had considerable nausea and vomiting, and had lost a great deal of sleep. Shortly after her discharge from the hospital she complained of anxiety and fear. Insomnia and anorexia became troublesome. There were many paranoid delusions and ideas of reference. The patient was severely depressed and restless. Hallucinations were first noted in the sanitarium. She was given a full course of insulin shock therapy without recovery, and was taken home against advice. She again became disturbed and was admitted to the sanitarium on May 17, where she remained until August 3, 1940. During this period she was given six metrazol convulsions. When discharged she was still paranoid, confused and lacked insight. After a few months at home she was committed to the State Hospital.

* * *

Case 5.—Mrs. M. A., aged 22, was first seen January 26, 1940, three months after the puerperium because she had taken her two children to different homes in preparation for suicide. The patient had always been introspective and depressed in nature. About one month after her child was born she became severely depressed and apprehensive. She gradually became more depressed, was confused and apathetic. A full course of insulin shock therapy was given with good results, and she was discharged on May 6.

* * *

Case 6.—Mrs. M. T., aged 23, became confused and disturbed a few days after the puerperium. Delusions and hallucinations rapidly developed. Treatment was delayed for several weeks until surgical repair of a third degree laceration could be completed. A full course of insulin shock therapy was given, and the patient made a complete recovery, leaving the sanitarium nine weeks after admission.

* * *

Case 7.—Mrs. O. W., aged 26, was first seen August 26, 1941. Several weeks after the birth of her child in May, she became nervous, was troubled with nausea and extreme restlessness. She expressed many delusions and had several periods during which she had visual hallucinations. In the sanitarium she became violently disturbed, antagonistic and quite confused, delusional and hallucinatory. She was given a full course of insulin shock therapy and seemed to be quite well on discharge. She relapsed shortly, returned and was given four metrazol convulsions and discharged. She had several minor epi-

sodes which necessitated her returning to the sanitarium a few days each time. Because these preceded the menstrual period, progesterone was administered in the premenstrual period and seemed to be beneficial. She recently reported to the office, seemed quite well, and stated that she got along much better when she had received progesterone before each period. She has been considered a social recovery.

Case 8.—Mrs. W. C., aged 23, was admitted to the sanitarium November 12, 1941. About three weeks after her child was born she became ill, and when seen a few days later, was catatonic and mute. In the sanitarium she was at times very listless, often badly disturbed. For several weeks she required forced feeding. She tried to vomit everything given her. She received insulin shock therapy and made a complete recovery, being discharged March 20, 1942.

Case 9.—Mrs. C. C., aged 32, was first seen February 11, 1942. She had gradually become more nervous, beginning a few days after the puerperium. She became delusional before she left the hospital, and when seen a few days later she was extremely agitated and antagonistic. She identified herself with the Deity, thought her food was poisoned and had auditory hallucinations. She was confused and disoriented, often depressed. She was given a full course of insulin shock therapy which, because of incomplete recovery, was followed by three electroshock convulsions. She showed considerable improvement, and was taken home on April 26; but, becoming disturbed, she was committed to the state hospital.

Case 10.—C. Z., aged 26, was first seen September 14, 1942. Following the normal birth of her child six weeks before, she had become progressively more nervous and depressed. Three weeks later she slashed her wrists and was hospitalized three weeks before coming under my care. She was markedly depressed and wept frequently. Restlessness was marked, and the patient stated that she felt confused, though she showed no evidence of this. She was self-deprecatory and self-accusatory. Insomnia was marked. She was given five electroshock convulsions, improved and was discharged. She relapsed and returned October 7, and was given six more convulsive treatments with marked improvement. She was finally discharged on December 6, 1942, though still somewhat unstable emotionally. She gradually improved and was discharged as well January 15.

Case 11.—Mrs. A. M. became confused and fearful ten days after her child was born. She had insomnia, was mildly delusional and tried peculiar ways of feeding the infant. Because the family refused to send her to a sanitarium, the patient was treated at home under the care of a nurse. She received fifteen units of insulin, three times daily before meals, castor oil daily and adequate sedation. She improved after a few weeks, relapsed and then went on to complete recovery.

COMMENT

Nine of the eleven cases reported in this article resemble dementia praecox, two are depressive states. All but two of the cases reported made a good recovery. These were both cases of dementia praecox type. Another patient, with a schizophrenic reaction, requires progesterone during the week before the menstrual period in order to avoid severe nervousness and irritability, and should probably be classified as having made a social recovery. The average period of hospitalization for the patients who recovered was slightly less than four months.

Before the advent of shock therapy the course of illness was long, regardless of the type of disturbance, and while the recovery rate was relatively high in the manic-depressive and toxic-exhaustive groups, it was very low in the schizophrenic group. Strecker and Ebaugh,[2] in a study of 50 cases, found an average period of illness of eight months with a recovery rate of 72 per cent in the manic-depressive cases, and an average illness of more than eleven months in the toxic-exhaustive group, with a recovery rate of 76 per cent. In the dementia praecox group the average duration of illness was more than eight years, and no patients recovered though 2 out of 13 were noted as improved. Karnosh and Hope, in their report, stated that in the schizophrenic group 71 per cent failed to recover.

REFERENCE TO THE LITERATURE

In reviewing the literature one finds very little pertaining to the modern treatment of the psychoses following pregnancy. In regard to the schizophrenic states in general it is universally accepted that insulin shock offers the best results if used early in the illness. In the manic-depressive psychoses, especially the depressive phase, convulsive shock is considered preferable. Kraines[4] reports nine cases of psychiatric states following pregnancy, which were treated with convulsive shock therapy only. He does not group these cases but reports them as a whole. All but two recovered and the illness in no case exceeded four months. Kraines feels that the important factor in treatment is the early application of shock therapy. He also noted benefit in one case where the menstrual period was preceded by emotional instability with the use of testosterone proprionate for a few months. Schmidt[5] reports recovery in one case, which he attributes to the use of progesterone in large doses preceding the menstrual period. This author cites Kraines' experience with testosterone proprionate, and states that "the action of this hormone would be the same as that of progesterone as regards their relationship to the estrogenic hormone." Schmidt also feels that the postpartum psychosis is a clinical entity, and states that the prognosis is quite favorable for recovery in all cases. This is certainly not consistent with the opinions expressed in the literature, and does not coincide with my conception of the problem.

ON PROCEDURES IN TREATMENT

In the management of a case in which mental illness develops following pregnancy, the author considers it advisable for the patient to be institutionalized as early as possible. Generally a period of observation for about two weeks is recommended, and during this time the patient is given 5 to 20 units of insulin before each meal, and

castor oil daily. Treatment is otherwise symptomatic. Psychotherapy is utilized if considered advisable. If the patient improves sufficiently, shock therapy is not recommended until improvement ceases, as a small number of patients will recover under this régime.

If the course of the illness is not satisfactory, shock therapy is then instituted. Insulin shock is strongly advised in the cases with a dementia praecox type of reaction. This is in accord with its use in dementia praecox generally. Electroshock has entirely replaced metrazol in convulsive shock therapy, because of ease of administration and relative freedom from complications, and is the treatment of choice in the manic-depressive type of reaction especially the depressed phase. While the use of convulsive therapy does not change the recovery rate to any marked degree in the postpartum depressions, it does substantially reduce the period of hospitalization, and probably increases the rate of recovery. Convulsive therapy is also used, in the few patients who do not show a complete recovery with insulin shock, often with excellent results. Electroshock therapy is considered preferable to symptomatic treatment in those cases of schizophrenic reactions where insulin shock cannot be utilized for various reasons. Progesterone should be tried in all cases in which the menstrual period is preceded by emotional instability and tension states. The advent of shock therapy has completely changed the prognosis in puerperal psychoses.

CONCLUSIONS

1. The mental illnesses which follow pregnancy constitute an indication for shock therapy. They primarily depend upon the constitutional makeup of the individual, though the precipitating factors as yet are unknown.

2. Unless properly treated early in their development, the prognosis in the so-called puerperal psychosis is poor.

3. Insulin shock is preferable in the dementia praecox type of reaction, but should be followed by electroshock if recovery is incomplete.

4. Electroshock is the treatment of choice in cases showing chiefly depression.

5. Progesterone may be of benefit in those cases with premenstrual tension.

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DERMATOLOGIC MANAGEMENT: SOME FUNCTIONAL CONCEPTS*

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WHEN one becomes chairman of a section, he is expected to give an address on whatever theme he wishes. He is given a free hand and discussion is barred. He may, therefore, say what he pleases and remain unquestioned. I have acquiesced in this prerogative and hope that the conception of this paper will be accepted as sound and thought-provoking.

By a functional concept in dermatological management, I mean that I am turning my thoughts to the functional disturbances that underly many of the phenomena of skin changes. This is not so much directed toward the experienced dermatologist, but to the tyro who has learned a formula by which to treat a diagnosis. This person must broaden his conception of management to include such factors as the individual as a whole, his color, age, and skin type, his physiology in general; the physiology of the part involved, and finally the physiology of the disease process itself. It would be far better if we could scrap all "name diagnoses," and adopt pathological ones. If the intricacies of the phenomena could be so condensed, our students then would not think in terms of a name, but in terms of physiological and anatomical changes.

Unfortunately, the discoveries of specific microbic agencies and specific deficiencies have had a limiting effect on the practice of medicine and its teachers. These have, in their acceptance, caused a neglect of associated causal factors without which no disease could exist. Medicine has been led into a search for new diagnostic procedures, and those, such as chemistry, bacteriology, radiology and endoscopy, have been so applied. The search for accuracy has over-reached symptomatology; objectivity has become paramount. We are now turning away from the focus of infection or focus of irritation to one of consideration of age, sex, heredity, physical type, and temperament, as well as emotional and occupational stress. With these, we must combine eating habits, relative to food and its mineral and vitamin factors; and consider the individual's ability to absorb and utilize these factors in a normal and effective manner.

It is necessary, therefore, that we get away from nomenclature and classification as the main objective of diagnosis. All symptoms are specific phenomena for a physiological process or disturbance referable to a variety of changes or stresses.

DIAGNOSTIC AIMS

The first aim of diagnosis should be to discover the physiology of a symptom or functional error,

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and only then to determine whether it is due to emotion or fatigue, constitutional change of body-chemistry, or a variable of the utilization of the food and vitamin factors. These changes may be disclosed by wheal formation, infiltration, eruption, ulceration, and all the other manifestations of disturbance of the nutritional and normal life process of the cell.

The field opens to an immensity that cannot be touched in one short paper or by one man's restricted knowledge of many phases of the physiology and chemistry of the human organism. I have selected only a few instances out of my experiences.

We can start with an axiom, "The normal body is a healthy body; therefore, the normal part is a healthy part." With this in mind when in the presence of a skin condition not explainable by the external attack of agencies that would injure any skin to a like degree, we must ask ourselves, "Why does this individual react differently than those around him? What functional change is present that makes him react with a lowered threshold and in an abnormal way?"

CASE EXAMPLES

I will give you the example of disseminated neurodermite (Vidal). These cases have a skin that reacts in a characteristic way on any part of their skins if frictional trauma is there applied. Their complaint includes one of general skin irritability, coupled with an over active nervous habitus. A careful survey of their living habits will often bring out defective mineral nutrition and psychic conflicts. If we occlude a single lesion from injury for a sufficient time, it recovers. We then may call it a "contact dermatitis." It is true that it responds to contact, but the skin has an inherent irritability that a normal skin does not have. We can then conclude that there is a disturbance of the function of this skin that permits an abnormal reaction to physical damage. If we subscribe to the nervous origin of this condition, we are no better off. We had better ask, "Why is this patient nervous?" "What constitutes nervous tension?" "Why do we have the neurotic?" The psychiatrist may answer the above to his own satisfaction, but is he entirely right or has he, too, neglected the chemistry and physiology of the organism that must be maintained in balance? "*Mens sana in corpore sano*" can become more than a schoolboy phrase if we apply it to medical practice. A careful dietetic survey will commonly show these patients to be restaurant diners or lunchpail eaters: if they are women they don't drink milk, and if they are men they consume substantial meat and potato meals without salads, fresh vegetables, fruit or other refinements. Neither sex eats much fresh fruit. Neither one has a proper mineral or vitamin intake.

These cases must be restored to a normal balance in eating, mineral intake must be increased, and the necessary vitamin content supplied for their utilization, if we are to get more than the symptomatic relief provided by ointments, x-ray and protective dressings. I have found it good practice to provide an added calcium and Vitamin D ration at the start of treatment.

* * *

Another good example of functional upset that illustrates my point is that of the patient with varicose veins, ulcer, varicose dermatitis, and a light sensitive dermatitis of the arms and face. We can break this case down to the first nutritional damage in the leg area. This is the start of a vicious cycle that has been seen countless times. This follows the steps of slowing of the blood stream due to venous damage, with dilitation of the veins and incompetancy of the valves. With slower flow, the nutrition of the vessel suffers and further damage is added, again causing further dilatation and further slowing. The column of venous blood becomes heavy, and capillary flow becomes almost stopped. A portion only of the murky contents of the vessel gets back to the heart, the rest recirculates in the leg. The catabolic products accumulate, cellular disintegration occurs, platelets adhere to the damaged intima and dissolve, releasing a histamine-like substance. Serum proteins and globulins accumulate and become modified. Cellular infiltration and sclerosis of tissue occur, and further nutritional damage results. The overlying skin erupts or becomes necrotic, eczema and ulcer appear. As histamine-like substances spread through the circulation, the individual becomes photosensitive. These are the cases that storm our offices after the first sunny days in spring with the fiery red arms and faces. They are like photographic plates awaiting the opening of the shutter.

At the same time as the above is taking place, a psoriatic individual develops his most resistant lesions over the bad leg areas, and if he has lichen planus, the lesions overlie the dilated blood vessels and ulcer sites. If lichen simplex chronicus occurs, it is likely to choose the leg with the nutritional damage.

In these cases, large doses of vitamin C, support of the circulation by firm bandaging and the injection of chemicals to increase the oxygen-carrying power of the blood (Tetrathione), have given the only lasting good results. These results are obtained not by medicines or ointments, but simply by the reversal of the breakdown cycle.

KELOID

I would like to discuss another condition that develops apparently on a functional basis, and that is keloid.

I have seen keloids develop under a variety of circumstances.

REPORT OF CASES

CASE 1.—The most discouraging that I remember was the case of a child burned with hot coffee. A first and second degree damage only, over the chest and left arm. Healing was complete and perfect in about one week, hardly a trace of scar being present; but two weeks

later a rapid and dramatic keloidal development occurred, disfiguring the child's body very badly. I now ask why, after perfect healing did a delayed keloid occur? This indicates with certainty a dormant functional change that reactivated fibroblastic growth after a latent period in which healing was apparently complete.

Case 2.—A second instructive case was that of a young girl who spilled boiling candy over the entire back of her fingers and hand. I saw her only after the lesion had healed with an unsightly and rigid keloid. I started her on x-ray treatment. She improved slowly but considerably, and was about through treatment six months later. Three months after practical dismissal, she returned with new keloids under her fingernails, and the nails were split by the growth beneath them. She gave the history that she had taken up piano playing before the changes began. I did not want to give her further x-ray, and instead stopped her playing and bandaged the tips of each finger with elastoplast (Duke Lab.), and kept them so covered for eight weeks. By this time the keloids had gone and the hand was back to normal.

Case 3.—A third case was that of a child that developed a palmar keloid from falling and burning the hand on a stove. This keloid had distorted the hand into a tetany form and had persisted for a year. The keloid was webbed in type binding the thumb toward the palm and cupping the hand. I applied no x-ray, but instead wrapped the hand in elastoplast to immobilize it and remove all tension. In two months the keloid had absorbed and function was restored. This keloid may have regressed spontaneously, but I don't think so, since it had remained unchanged for over one year.

COMMENT

These cases show that keloid is a latent property of skin healing. In the first case, no traumatic factor seemed to operate. It was apparently a physiological one. I feel from this case that keloids should be preventable, and are probably due to a mineral or hormone imbalance not yet explainable by our present knowledge. The other two cases show the rôle of, 1. Trauma and, 2. Tension. When both were relieved, healing took place. It was therefore a reversable process without the added rôle of x-ray. Spontaneous regression also does occur without relieving tension or removing trauma. These cases are the reverse of the first type.

OTHER CONDITIONS

Alopecia areata has also seemed a condition in which functional management applies. The hair is supposed to fall following nerve trauma that produces persistent vasoconstriction of the capillary plexis at the base of the papillae. The area becomes smooth and the appendages undergo atrophy. If a case is recovering spontaneously, the skin resumes a reasonable appearance of normality, the follicles become noticeable structures and hair begins to grow. Methods of stimulation have failed to produce much response if on the order of applications of phenol, cresol, or ultra-violet light. If growth is started, it is likely to be colorless. If we proceed somewhat differently, and freeze the area for 5-10 seconds with firm pressure with carbon dioxide snow, we get brisk stimulation; but in addition, produce a paralysis of the vaso-constrictor nerve fibres, so that dilatation and erythema are prolonged. The hair growth is accelerated over the other methods, and the hair retains natural pigment from the start. If we give calcium and vitamin D without freezing, the white phase is also absent, probably due to the known sedative and relaxing action of the calcium on the nerve endings. The cases that do not respond to this method of attack are few.

The effect of vitamin D treatment in *sclerodermia and roentgen sclerosis* was reported by me in the Archives of Dermatology and Syphilology, in May, 1940 (Vol. 41, No. 5, pg. 842). Since that time, a larger series of cases have accumulated, and continued to give favorable responses. I believe that the application of this form of therapy is particularly beneficial, and therefore a "must" in treatment of roentgen sclerosis. I further suspect that it may be used prophylactically. If telangiectasia of roentgen damage results from the sclerosis, this may also be prevented. I do not think it will help after the vascular dilatation has taken place. The softening of the areas has been definite and positive.

The theoretical basis of this response is the same as in sclerodermia. Calcium is increased in the areas, and therapy that modifies this factor is one to aid.

Low calcium diets would seem to be indicated, and I have used them in some cases and not in others. Perhaps we should consider the premise that the calcium is remetabolized rather than excreted. Keloids likewise contain considerable calcium, and may contain grains of calcareous material. I have given burn cases calciferol routinely. I am not satisfied that there has been any effect.

Therapy of *acne* has been little changed in basic principals. I do not consider x-ray to be the therapy of choice. My management for the last 18 months has been satisfactory in the use of combined vitamin A and calciferol, with intramuscular calcium gluconate (10 c.c. of 10 per cent intragluteally 2 times a week) to control periodic flares of the process or to get quicker control of a bad case. I use x-ray reluctantly, and only as a rare aid in the above management. I have not given "courses" of x-ray treatment since 1933. It should be added that care and patience in such cases is a prime requisite.

OTHER FORMS OF VITAMIN THERAPY

To consider all other forms of vitamin therapy would involve the writing of a book. I use vitamin B as a complex, and add the fraction I wish to emphasize. I have recently been puzzled by the failure to get a complete response in an old lady with ariboflavinosis, until I learned that riboflavin is rapidly destroyed in the absence of hydrochloric acid. These, therefore, must be given as a combination in an achlorhydric individuals. I use vitamin A alone in the defects of keratinization, and have seen benefit in hyperkeratoses of the

palms and soles. Some effect results from the use of vitamin A in icthyosis; it is not complete, but the skin withstands the usual traumata to a more normal degree, and patients speak of more comfort. I likewise give it combined with vitamin C and D in the case of senile eczema.

Vitamin D (Calciferol) has given some beautiful results in psoriasis and in other cases only a very slow change, if any. I use it, and keep patients on it for a year. I don't give extreme doses, 50,000 units daily seems to be satisfactory.

You will realize that this has been an abstract consideration of procedures that are not universally accepted and used, but have led to a degree of success in management that I believe to be superior, and more on a functional basis than many that are in general use today. Each incident perhaps should be the reason for a fuller investigation than is presented here.

The purpose of this presentation is to indicate a few pathways away from textbook formulas, and from x-ray therapy. It is also to suggest that some of our homely ruts should be abandoned.

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CALIFORNIA PHYSICIANS' SERVICE*

CURRENT ACTIVITIES

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GREAT movements at their start often are not recognized for their true value or on the correct basis.

The human mind, however, senses long before actual performance, these trends toward great needs of society. Each one of you can enumerate such great movements through history. For me today to name these would be a surfeit of words and would not be of any value save to liken the subject, of which I speak, to a movement of great worth. I speak of California Physicians' Service. To me, this endeavor is not a small project of experiment, but it is an expression of part of a great human movement which will raise the quality of human relationship, both physical and mental.

BEGINNINGS OF STATE-WIDE MEDICAL SERVICE IN CALIFORNIA

Most of you remember the seeds of this growth, though sometimes that remembrance is dulled by irritating details of present performance. First, at the Riverside meeting of this House of Delegates you remember the great surge of incentive and oratory that enveloped our profession. Then came the special meeting of the House of Delegates in Los Angeles, which dealt with a grand survey. Thereafter, came conflicts with advertising clinics which had, what many considered mistaken, ideas of how to accomplish prepayment medical service. Then came the compulsory proposals by the legislature and misguided political interests. Then through it all we see the efforts of hospital and medical men, directed toward the welding of professional needs with practical necessities and the proposal of our C.P.S. We may be proud that in all the United States, California men first had the temerity to attack, on a State-wide basis, this problem of great difficulty and technical distress. The fact that they held uppermost at all times the real issue involved (i.e., the greatest benefit to the poor, sick patients) is probably best proved by the fact that such mistakes as were made, were made by the attempt to provide the whole answer at the start, rather than to add step by step till the ladder reached the desired level.

Public ability to grasp sudden changes is far below the vision of great leaders.

I was interested recently in discussing this subject with an Eastern man who is associated with a highly successful hospital and medical plan. I asked him to tell me what eventually they hoped to do. "We have somewhat the following plan. First, get great numbers of members in the hospital association. Then in conjunction with the medical profession offer surgical care when *in* the hospital. Then add such medical care as needed for cases *hospitalized*, such as pneumonia, cardiac decompensation and such serious diseases. Then add in succession these services to dependents of the employed man. Such plans will be eminently successful and will solve most of the needs ascribed to failure of an individual to cope with catastrophic illness." He went on to say that the additional growths and steps of this plan came as the members realized the great value of the services and were the result not of a change of need but rather an awakened mass intelligence.

I remarked that he apparently hoped that they could some day offer to a needy public the very thing that C.P.S. was already offering.

WHY PROGRESS WAS SLOW

The fault with our plan,—and fault there was,—lay in entire inability of public psychology to accept and support the program. I include in this failure both the doctors and the public.

Time has tempered good plans with a knowledge of the need to lead slowly and the trustees of C.P.S. have made changes which will lead to success. The promise of C.P.S. has been all in all up to recent date, but now we are beginning to see the *fulfilment* of what we may expect. Now let me give you a few of the facts. When C.P.S. started, the full-coverage plan for the employed person was put in effect. We, as doctors, expected the type of use of the plan would be the same as the type of service offered. We found in the transition from a fee basis of service to a prepaid type, that people were moved to the extremes of use. The success of that plan was doomed, because 15-20 per cent of the beneficiaries demanded

* Address given in the first general meeting of the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

extra, out of reason service, and spoiled the whole thing. This mistake was unavoidable because there were no statistics anywhere on which an actuarial basis could be built. We are now the only medical care plan, backed by the medical profession, that has statistics based on facts and actual experience that can be presented to or given a hearing by actuarial experts.

PRESENT ORIENTATION

Our strongest point now is that we have actually been in the business and we know. Formerly, we were considered a straw man and easily pushed over; but for the last one and one-half years the scoffers have realized we really mean it. We have found that in medical care there are two main classes of service—

1. *The Elective Services.* Under this class are those things which to the patient are necessary to supply an emotional need—a fear—a phobia—a desire for a check-up physically—a refraction of his eyes. These needs are elective.

2. *Nonelective Services.* These needs embrace real illnesses—pneumonia—coronary attacks—appendicitis—broken ribs—kidney stones. I need not elaborate—you medical men grasp it immediately.

We are now seeing that elective services should be on a personal or fee basis. The nonelective are those things which are of a common-need basis and should be covered by a prepaid provision. This simple distinction can well be the only criterion needed. Under this plan people who go to the doctor under C.P.S. are sick—those who just are "going to the doctor" go on their own fee responsibility. Now, how can we adjust this and how is it to be done? This is the present status of C.P.S. and its current activities. C.P.S. has discontinued writing full-coverage contracts. There are some of the old original ones still in force but they are being converted as rapidly as the bookkeeping can physically be done. The next few weeks will bring that phase to a close.

TYPES OF BENEFICIARY CONTRACTS

There are only two types of general contracts to beneficiary members being sold—

1. *One policy, the surgical,* furnishes a basic surgical contract. This includes care of all cutting operations, fractures and dislocations. Laboratory and x-ray examinations needed in the treatment of these conditions are, of course, included. Preëxistent conditions are cared for if they are surgical in nature.

2. *The other policy is a two-visit-deductible policy.* This policy, in addition to the surgical care, provides medical care also, but the patient pays the cost of the first two visits of each separate illness himself. Only on the third call does the C.P.S. contract take up the cost.

We find several interesting things. First:—the type of people who desire these contracts is of a higher type as a whole, because they do not expect to take wrong advantage of their contract. Second:—these contracts return people to "normal habits" of medical care. In effect, we have now only added the prepayment feature to that part of medical care that is reasonably free of abuse by the patient. Those things open to abuse are still on the old relationship of a fee basis between doctor and patient.

It is interesting and comforting to see the unit of value to be steadily rising on this solid foundation. The current checks in the mail which are for work done in February are on the basis of $1.75 a unit. To quote Dr. Larsen, "We believe that most of the faults have been corrected and that we are well on the way to show you some real results." He further states, "Under our new two-visit-deductible plan, the member is to pay you for the first two visits. If x-ray, laboratory tests or surgical operations are necessary during the first or second visit, their cost will be paid by California Physicians' Service. The members' dependents (spouse and children, ages 30 days to 18 years) are now being offered care for surgical operations, fractures and dislocations. This 'family plan' is proving very popular among the married members and our membership is increasing each month."

MEDICAL SERVICE IN HOUSING PROJECTS

Now, one thing more before I finish. You have heard of our Housing Projects contracts. This phase really started January 1, 1943. The U. S. Department of Health and the Federal Housing Authority requested that C.P.S. help solve their problem. They sought an agency of the doctors—they did not force or order us to do anything. As a result, at Linda Vista, in San Diego, at Vallejo, Marin County, San Pedro, and at other housing projects, C.P.S. has offered and started medical centers under the control of C.P.S. There must be no misconception of what this is. Occupants of the projects, who are beneficiary members of C.P.S. 100 per cent, go to the medical center for first aid or emergency service. From there they are directed to the *doctors of their choice,* if the patients need further care. The Center filters out irritating, unnecessary calls which might otherwise be made on busy doctors. It filters out abuse of the plan right at its origin, but it assists in the legitimate working of the plan. The offering of this plan has so far made it unnecessary for the Public Health Service to put Federal doctors into this State as has been done in some other States. There are two million people in the U. S., outside of California, for whom F.H.A. is providing direct Federal medical care already. Unofficially, Federal representatives have said that California is the only State in the Union in which the medical profession has set up an instrumentality which they prefer to use instead of going direct to Federal medicine.

COMMENT

But not all are pleased with this success. To have the Medical Profession provide the correct

answer does not fit in with a plan which as Dr. Goin has said envisions transforming "unorganized confusion into regimented chaos."

Such people hope in some one of these projects to sabotage the whole effort. To accomplish such ends I am told they seek first to use the medical men themselves. Seeds of distrust—words of disparagement—visions of quick financial returns while good times last—these blandishments it is hoped will dissuade from the real issue the support of the medical men in these important areas.

Such tactics are not easily discerned until well under way. Even the best of us are deluded at times. For that reason only I am throwing out this one note of caution. May it never be said truthfully that the Medical Profession has been cleverly manipulated by a few to accomplish the destruction of an endeavor of such great worth. Honest recognition of our problems is laudable. Constructive change of plans is always right. So too until such changes have been made, unwavering support should be given by honorable men to the product of their travail.

DR. KILGORE'S STATEMENT

Dr. Alson Kilgore has so ably stated the case in a letter to the *Open Page* of the Los Angeles County Medical Bulletin that I am going to read you his words:

"Probably none of us on either side of the C.P.S. debate of 1938 foresaw 'exactly the situation' of thousands of war workers and their families, concentrated in new housing projects with no medical care in nearby towns (3,600 people live at Marinship today and this number is rapidly increasing. Sausalito, the only adjacent town, has three physicians, already busy in the town itself.)

"If one will ask himself what he would do as a member of a housing authority, responsible for reasonable facilities in these new communities, the answer is, he would see to it that, in some way or other, medical care is made available.

"Waiting for individual physicians to establish themselves for practice in or near these housing projects is impossible. So far, to my knowledge, no physician has even offered to try it.

"There are alternative methods. The U. S. Public Health Service could secure physicians (in effect through the draft), put them in uniform and on salaries—straight government medicine. Employers can set up their own plans, as Mr. Kaiser did, with physicians on salaries. Profit-making health service organizations could contract to furnish care—with physicians on salaries. Or the medical profession, through its own service organization, C.P.S., can undertake the job, employing physicians to furnish service necessary on the projects and referring patients who require more extensive work or hospitalization to any C.P.S. professional member whom the patient may select. But there is no alternative to the employment of physicians by someone or some organization.

"Faced with this practical and very urgent and pressing situation, is it better that the government or a private contractor take these people entirely away from the medical profession as patients, or that the medical profession undertake the job itself, controlling standards of service and preserving as much as possible of 'free choice' and the valued patient-physician relationship?"

IN CONCLUSION

There you have the picture. It is perhaps crudely drawn for I lay no claim to be an artist. My only hope is that it may call out your support to a great movement of medicine, which in my humble opinion holds the answer to one of the great needs of society.

2212 West Third Street.

BONE PLATES: A NEW TYPE*

KENNETH TOWNSEND, M. D.
AND
CHARLES GILFILLAN, M. D.
Los Angeles

THE employment of metals in the repair of human tissues dates from the time of Fabricius who, in 1647, used metal for suturing soft tissues. As early as 1775, Isart used metal in fixation of fractured bones. However, the modern conception of bone surgery, especially the open reduction and the revived experimental use of steel in fracture treatment, started with the work of W. A. Lane.[1, 2] He began his first use of metal in 1892, and his plate design continues to enjoy considerable popularity. Following this work, many varieties of metal were used in the construction of bone plates; namely, steel, German silver, silver, aluminum, copper, brass, and vanadium steel. But these metals have proved so intolerable to tissues they have been replaced by two recently-developed metals: vitallium and stainless steel. These latter metals are well tolerated by tissues, and of the two vitallium is slightly less electrolytic. It is, however, a cast metal and contains faults, while stainless steel is a machined metal and is, consequently, much tougher and less brittle than vitallium.

LANE'S PLATE

In the past thirty years there have been few variations in the design from Lane's original plate. Souttar,[3] in 1913, introduced a plate made of "thin-material," and constructed in the form of an angle-iron, one side of which was inserted into slots previously made in the bone fragments. (See Fig. 1.) The opposite side of the plate contacted the cortices and contained holes through which screws were passed to anchor the plate to the bone. Twenty-five years later Hawley and Padula[4] presented their angle-iron plate which was constructed of stainless steel. (See Fig. 1.) In design and method of fixation, the Hawley-Padula and Souttar plates are essentially the same.

AUTHORS' BONE PLATE

Keeping in mind the advantages and disadvantages of plates previously employed, we have

* Read before the Section on Industrial Medicine and Surgery, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

From the Department of Orthopedic Surgery, College of Medical Evangelists, Los Angeles General Hospital.

attempted to construct a bone plate which better serves the purpose of fixation, and yet eliminates, as much as possible, the faults inherent in the older plates. This new type of plate is constructed of austinitic stainless steel (18-8), is 20 cm. long, 1.4 cm. wide and has an overall thickness of 0.4 cm., though the actual thickness of the metal of the plate is 0.07 cm. Oval slots, 1 cm. long and 1 cm. apart, serve as screw holes. (See Fig. 2.) These slots are slightly wider than the shaft of a 6-32 or 6-20 stainless steel machine screw. The plate, instead of being flat, has a corrugated structure, roughly "M" shaped in cross section. (See Fig. 3.)

ADVANTAGES

In breaking down the various components of the plate one will note the following advantages:

1. Stainless steel construction reduces to a minimum the chance of plate fracture, and makes for ease of moulding of the plate to the contour of the bone.

2. The length of 20 cm. will allow for adequate bridging of all single and many double fractures. Because of the light gauge of metal used in the construction of the plate, it can readily be cut to the length desired by the operator at the time the fracture site is exposed, thus eliminating the necessity of various lengths of plates at the table. This advantage allows the surgeon to cut the bone plate to the exact length he wishes.



Fig. 1.—Angle-iron type bone plates. The non-perforated arms of the plates are fitted into previously made slots in the cortices of the bone fragments.



Fig. 2.—Author's bone plate showing slotted screw-holes as seen from top of plate.

3. Oval slots eliminate the counter-sunk screw holes, thus allowing the screw to slide lengthwise in the slot, this in turn facilitating absolute reduction of the fragments. These slots have three distinct advantages.

First, when counter-sunk screw holes are present, it is necessary to have the drill hole in the bone conform to the plate screw hole accurately within a few thousands of an inch; otherwise, when the screw is sunk into position, the far cortices of the fragments will be in contact and the near cortices will separate. With oval slots, this extreme accuracy is eliminated.

Second, the oval slots assist the operator in obtaining accurate anatomical approximation of fragments, viz., if the plate is in place, the screws in the center of slots, but have not been completely tightened, and the fragments well aligned and the operator, on examining the fracture site finds a gap between the ends of the fragments, impaction is easily and accurately accomplished without danger of loss of position, by exerting firm pressure on the distal fragment toward the fracture line until the two opposing cortices are in contact.

Third, muscle pull will always tend to keep the fracture surfaces together, lessening at the same time the tendency of the plate to angulate or bend.

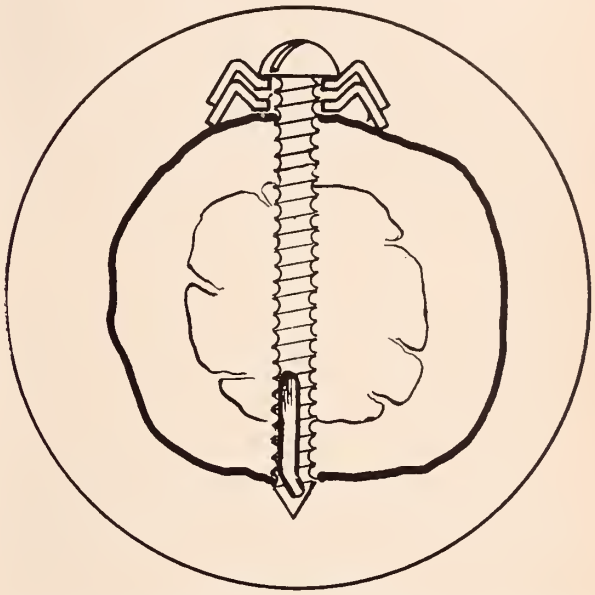


Fig. 3.—Shows cross-section of bone with screw passing through both cortices and holding two plates against outer cortex. Also shows cross-section of two stacked or "nested" plates.

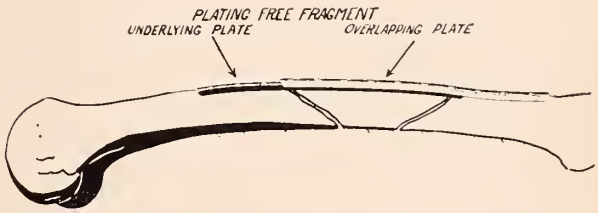


Fig. 4.—Shows side view of two plates illustratir "nesting" and longitudinal staggering.

4. The corrugated shape of the plate has several advantages. This form of construction allows two or more plates to be stacked, nested or laminated, one on the other, increasing the actual thickness only by the gauge of the metal (0.07 cm.) per plate. (See Fig. 3.) Stacking or nesting adds strength and, more important, provides a form of leaf spring action. Thus, under stress of a sudden muscle contraction, which would have a tendency to fracture or permanently bend a single cast type plate, the laminated plates will spring slightly at the fracture site until the force of the muscle pull is balanced. Then, when the muscle relaxes, the plate will spring back to its original shape. The action of the plates is similar

to that of the leaf springs of an automobile. By this action no great amount of force is thrown on the plates or screws. The corrugated shape also allows lengthwise staggering of the plates. (See Fig. 4.) The importance of this is illustrated by the following example. Let us assume we are confronted with a double fracture of the femoral shaft; one fracture being subtrochanteric, the other supracondylar. Under this condition it would be necessary to use two conventional plates; one above and one below, making a point of weakness at the middle fragment, or where the two independent plates tend to contact each other. Here there is no continuous metal bridge from upper to distal fragment. By employing corrugated-shaped plates, one can make use of their ability for lengthwise staggering, and thereby form a continuous truss of metal from the upper across the middle and to the lower fragment. The weak point over the middle fragment is thereby eliminated.

On femurs two or more plates (two for a single fracture) are adequate. Six screws are used for fixation. For tibias and humeri one plate, fixed by four or six screws, is recommended. In our opinion four of the Tuk-Tap screws will hold sufficiently in tibial and humeral plating jobs.

For fixation of the plate we have, in our experience, found the Tuk-Tap 6-20 stainless steel (18-8) machine screw to be the most satisfactory. This screw has twenty threads to the inch, a sharp off-center point, and a single long flute. The off-center point allows for cutting of the bone threads on the first turn of the screw, and facilitates introduction of the screw into the bone with about 40 per cent less force than is usually required by the Sherman screw. Instead of using a No. 32 drill, such as the Sherman screw calls for, we find the smaller No. 36 drill will provide a more perfect fit for the screw with a greater bone to metal ratio, and with consequent greater holding power.

In our experiments on the holding power of screws, using fresh beef bone, we found the 6-20 Tuk-Tap screw to hold 46.5 per cent more than the Sherman 6-32 screw.

SUMMARY

A new type of bone plate is described and its advantages discussed. The advantages of the Tuk-Tap 6-20 stainless steel machine screw are briefly reviewed.

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SURGICAL TREATMENT OF INTRACTABLE PAIN*

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THE proper management of severe and persistent pain constitutes one of the major problems in neurological surgery. The situation is favorable if a localized space-occupying lesion is discovered which can be surgically removed. However, all too frequently there exists no objective explanation for the pain, and one is confronted with the problem of affording symptomatic relief by section of appropriate nerve pathways. At once there arise many difficult problems in diagnosis. One must consider the functional element, frequently the degree of addiction, and always the decision must be influenced by the severity of the pain versus the magnitude of the surgical procedure contemplated. There is probably no field of major surgery in which it is more vital to be fully aware of the therapeutic limitations of a given surgical procedure.

TRIGEMINAL NEURALGIA

The major neuralgias of the head and neck afford an excellent example of intractable pain. The symptoms develop without obvious gross or histological explanation, are severe, recurrent and localized to a given nerve distribution.

Trigeminal neuralgia, the most frequent and severe member of this group, has been much discussed, but there still exists considerable confusion in diagnosis. The frequent error is to consider atypical facial pain as true trigeminal neuralgia. The history of severe, sudden, shock-like pains is important, but hardly less so than the anxious, fearful expression of the patient and the reluctance to touch the painful area. One should proceed with caution if the pain is continuous and burning over a wide area which the patient cheerfully outlines by palpation.

The eventual treatment is surgical resection of the posterior root of the trigeminal nerve, but this should always be preceded by alcoholic injection. Injection should be done, not as a diagnostic procedure, but to afford temporary relief and train the patient gradually to the eventual complete anesthesia which persists following root resection.

There are several surgical procedures recommended. They vary in approach and certain technical features, but all have in common the production of complete analgesia. Experience seems to indicate that resection of the posterior root itself is the procedure of choice. The controversy of temporal versus posterior approach is probably best decided by the individual training of the surgeon. Tractotomy is not well established, and the benefits of this operation as yet seem overshadowed by added risk and occasional major complication.

* Read before the Section on Neuropsychiatry, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 3-6, 1942.

GLOSSOPHARYNGEAL NEURALGIA

Glossopharyngeal neuralgia is symptomatically identical with the other major neuralgias, and is confined to the distribution of the ninth cranial nerve. Pain is initiated chiefly by swallowing, and radiates from the throat upwards to the ear. Cocainization of the palatine fossa affords an excellent diagnostic test. Permanent relief is only obtained by intracranial section of the ninth nerve.

Interest and enthusiasm in surgery of the sympathetic nervous system has lagged somewhat in recent years, its current application being confined chiefly to peripheral vascular disease and essential hypertension.

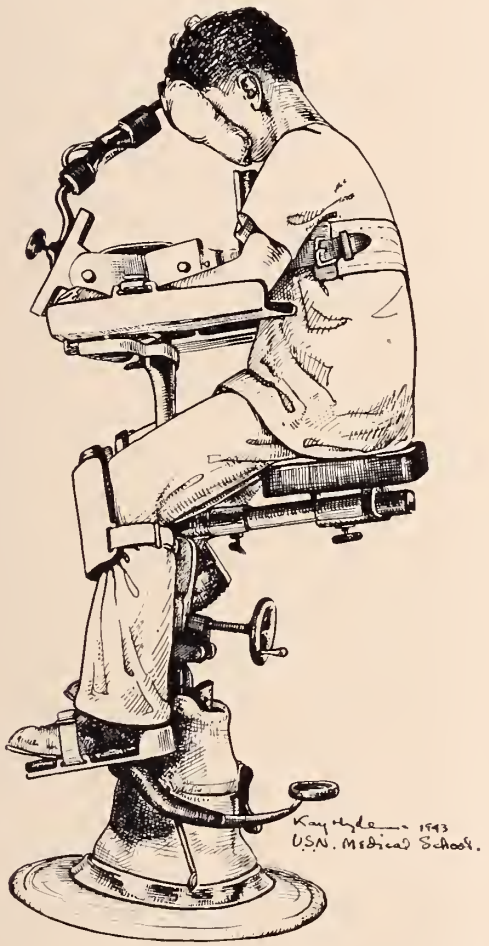


Fig. 1.—Patient in the upright sitting position for lumbar laminectomy.

CAUSALGIA

Causalgia, secondary to median nerve injuries, certain types of cardiac pains, dysmenorrhea and pain resulting from peripheral vascular disease, have been treated by sympathectomy. The results have been excellent in some cases, but not all patients have been completely relieved. If possible, it is advantageous to do a diagnostic novocain block of the respective sympathetic nerves before definitely advising surgical resection. It is not within the scope of this article to discuss fully all of these procedures, but there is one apparent sympathetic disturbance which might bear further discussion.

ZUDEK'S ATROPHY

Zudek's atrophy, or painful osteoporosis, is a poorly understood syndrome which results from minor trauma to an extremity and is characterized by intractable pain associated with obvious vasomotor disturbance. Limitation of motion and roentgenographic evidence of marked bone atrophy complete the picture.

The upper extremity is most frequently affected, especially the fingers and wrist. The injury is usually trivial, but occasionally it may develop secondary to a well managed Colles's fracture.



Fig. 2.—Position of patient readily altered by adjusting wheel connected with worm gear on case.

The hand and fingers become glossy, cyanotic and oedematous. The fingers are immobile in extension and attempted passive motion greatly exaggerates the existing pain. Spontaneous recovery may occur after months of disability, but not infrequently there is permanent ankylosis of the finger and wrist joints.

Sympathectomy, if done within the first few months, usually affords prompt relief of pain, the vasomotor disturbances subside and physiotherapy may be instituted without discomfort to the patient.

MALIGNANT LESIONS

Intractable pain, involving the lower extremi-

ties, pelvis and abdomen, secondary to malignant lesions or tabes, may be relieved by chordotomy. The ascending pathways subserving pain which comprise the spinothalamic tract are sectioned in the upper thoracic region. The laminated arrangement of these fibers is such that the level of analgesia is in direct proportion to the site and depth of the incision in the spinal cord. The most satisfactory results are obtained when the tracts are sectioned at the level of the second thoracic segment.

Chordotomy affords complete analgesia without loss of tactile sensation or impairment of motor power. The procedure may be done bilaterally without added surgical risk, and probably is always indicated in dealing with malignant lesions even though the pain be limited to one side at the time of operation.

Intraspinal subarachnoid injection of 95 per cent alcohol is frequently advocated as a more satisfactory method of dealing with intractable pain resulting from malignant lesions of the pelvis and extremities. The advantage of this procedure is simplicity and lack of surgical risk. The method is effective if the pain involves only two or three adjacent nerve roots, but attempts to control pain distributed over a large area are usually very unsuccessful. Furthermore, if large amounts of alcohol are used, there may develop permanent sphincter impairment, cutaneous anesthesia and even motor weakness.

Rhizotomy to control intractable root pain is justifiable provided the anatomical diagnosis be well established. If no demonstrable bony lesion is present, one should always bear in mind the possibility of an intraspinal tumor. Root pain due to a spinal cord tumor may antedate by months or even years the usual signs of cord compression. Before contemplating spinal root resection, it is obvious that careful neurological investigation should be done as well as lumbar puncture and cerebrospinal fluid studies.

PROTRUDED INTERVERTEBRAL DISK

No discussion of intractable pain would be adequate without consideration of the protruded intervertebral disk as a cause of chronic low back and sciatic pain. The symptoms and signs are familiar—history of minor trauma, immediate and recurrent low back and unilateral sciatic pain exaggerated by coughing, sneezing and lifting, positive Kernig and Lasegue signs, and the frequently-absent achilles reflex.

The excellent results which follow careful removal of a protruded intervertebral disk have led to widespread interest in the subject and greater accuracy in diagnosis. Limited exploration and partial hemilaminectomy, which afford adequate exposure without structural weakness to the spine, have done much to foster the present tendency for direct operation without utilizing air or lipiodol for localization.

Nevertheless, one occasionally fails to find an obvious protrusion even though the signs, symptoms and spinal fluid findings are typical. It is possible that the degree of protrusion may not remain constant, and that on occasion the process might be reversible. In an attempt to investigate this problem, roentgenograms of the lumbosacral spine were taken of the same patient in the supine and erect posture. With the patient in the horizontal position, a widening of the joint spaces was evident which might well so reduce the internal pressure of the disk as to allow complete reduction of the herniated portion.

It would seem logical to operate, with the patient in the position which would afford the maximum protrusion of the intervertebral disk. As demonstrated in the roentgenograms, there is an appreciable narrowing of the disk, particularly the anterior aspect, with the patient in the sitting position.

Upright Position.—An operating chair was designed for use in surgery of the posterior cranial fossa and upper cervical spine, which seemed to lend itself equally well to exploration of the lumbosacral area. The concept of surgery in the sitting position is not original, but, so far as I am aware, no attention has been given to the mechanical and practical advantages of this position in dealing with lesions of the lumbar and lumbosacral spine. (Fig. 1 and Fig. 2.)

I have already operated twenty patients in this position and have observed numerous advantages. The ease of operation, particularly with reference to the posture of the surgeon and assistants, is obvious. Visibility is improved, not merely because of the patient's position, but also because blood which might otherwise necessitate removal with a sucker, escapes by gravity. The position affords the maximum space between the lamina, thus reducing the amount of bone which need be removed for adequate exposure. The increased hydrostatic effect of the column of spinal fluid within the dura greatly compresses the large veins about the margins of the laminectomy, reducing to a minimum troublesome extradural bleeding. The weight of the patient increases the degree of pressure within the disk which, in turn, increases the size of the visible herniation and facilitates complete removal.

1930 Wilshire Boulevard.

That pulmonary tuberculosis is not uncommon in elderly persons is a fact that seems to fail to impress both the public and the physician, possibly due to the nature of the older body affected by a chronically progressive disease. Those who have studied pulmonary tuberculosis in the higher age groups are impressed with the lack of emphasis on this phase in the study of the disease. A flank attack on this weak spot would circumvent more circuitous methods to the same end, namely, the lessening of the general incidence of tuberculosis.—J. T. Freeman, M. D., and C. A. Heiken, M. D., American Jour. of Medical Sciences, July, 1941.

Tuberculosis remains predominantly a disease of adults in their productive years and causes invalidism, loss of earning power, expense of hospitalization and treatment. —A. C. Reid., Jour. Industrial Hyg. and Toxicology, Oct., 1940.

THE ORIGIN AND DEVELOPMENT OF THE SCIENCE OF ROENTGENOLOGY*

COMDR. JOHN D. CAMP, M.C., U.S.N.R.
Corona

TONIGHT we are gathered to pay homage to a colleague and friend whose professional career has been so closely related to the development of the science of roentgenology in this country, that the committee for this occasion has asked me to speak on the "Origin and Development of the Science of Roentgenology," a task so formidable that even Percy Brown, that master-historian of American Roentgenology, in 1933 prefaced a similar manuscript with the comment, "to compress within the confines of a few pages an adequate history of the development of roentgenology during its life of 38 years were a task well nigh impossible." That was ten years ago, and since then the life of this prolific child of science has developed many ramifying interests.

It has been said that "a science is a constantly metamorphosing structure of knowledge which is being erected by devoted artisans who utilize material derived from the vast resources of nature. One who aspires to toil at the building should first view its contour from a proper perspective and study its conformation in detail: he must appreciate the significance of its historic foundation, he will learn to know how its sustaining walls have slowly risen during the passage of time to lofty majesty by the consecutive addition of ingeniously-carved stones of proved fact, which have been quarried from the infinite depths of deduction; he will perceive how these adamantine truths have been superimposed and conjoined in precise alignment with preconceived diagrams, until fashioned into an edifice of such magnitude that a single human mind could not have designed nor comprehended its present ramifying entirety." How well the development of the science of roentgenology conforms to that definition—so well that it might have been written by a roentgenologist! It was.

ORIGIN OF THE SCIENCE OF ROENTGENOLOGY

It is most difficult to identify the origin of the science of roentgenology, for one must recall that the apparatus used in Roentgen's investigation evolved from the minds and labors of many notable scientists, such as von Guericke, Hawksbee, Nollet, Galvani, Volta, Faraday, Helmholz, Crookes, Lenard and others. All of these observers had contributed to the knowledge of the properties of electricity and its production, the creation of high-tension currents and their effects in highly-evacuated tubes. Roentgen's discovery of x-rays has been said to be the glorious finale, crowning the researches which had been carried on by others for many years. To those who call Roentgen's discovery an accident, Münsterberg replied: "Suppose chance helped. There were many galvanic effects in the world before Galvani saw by chance the contraction of a frog's leg on an iron gate. The world is always full of chances, and only the Galvanis and Roentgens are few."

ROENTGEN'S OBSERVATIONS

Immediately after Roentgen's observation of the fluorescent effect of x-rays, he conducted a number of carefully-planned experiments, the most important of which was the replacement of the fluorescent screen by a photographic plate, thus providing the cornerstone of roentgenology. Roentgen's preliminary report concerning his new kind of ray was submitted to the Würzburg Physical Medical Society on December 28, 1895, but was not published until January 23, 1896. In the intervening weeks, the news of his discovery traveled throughout the world with a speed that has not been equalled by any scientific discovery before or since. The world was ripe for such an announcement, for numerous scientists were experimenting with Crookes' tubes or similar phenomena, and almost overnight Roentgen's experiments were being repeated or enlarged upon. The medical possibilities of this new kind of ray were immediately seized upon, and as early as February 15, 1896, the *Journal of the American Medical Association* published an article entitled, "A New Kind of Ray." Even the fondest hopes of those first few weeks following the announcement were soon surpassed in the amazing development of roentgenology, which counted over 1,000 articles and over 50 books published on roentgen rays during the year 1896 alone.

REACTION OF LAITY

The reception of the discovery by the laity was not without its humorous side. The London Pall Mall Gazette said concerning Edison's discovery of the value of calcium tungstate as a fluorescent substance: "We are sick of the roentgen rays—the consequence of which appears to be that you can see other people's bones with the naked eye and also see through eight inches of wood. On the revolting indecency of this there is no need to dwell. But we seriously put before the attention of the government that the moment tungstate of calcium comes into anything like general use, it will call for legislative restriction of the severest kind." The imaginative instinct of those days is also reflected in a bill introduced into the New Jersey Assembly on February 19, 1896, prohibiting the use of x-rays in opera glasses at theaters, and again in the advertisement by a London firm of x-ray proof undergarments for women. Even *Punch* carried poems concerning the potentialities of the ray and cartoons of ladies wearing metal x-ray proof skirts. New York papers even re-

* Presented on the occasion of the seventieth anniversary of Albert Soiland, M.D., Los Angeles, a pioneer radiologist, May 5, 1943.

The opinions and assertions contained herein are the private ones of the writer and are not to be used as official or reflecting the views of the Naval Department or the naval service at large.

ported that the College of Physicians and Surgeons used the roentgen rays to reflect anatomic diagrams directly into the brains of the students, thus making a more enduring impression than the ordinary methods of learning anatomy. How many of us wish that there had been some grains of truth in that announcement! Even today cartoonists toy with the idea of the x-ray to establish a point, and the future combination of x-rays and television will be something to wonder at. I dare to predict that such a combination will come, and who knows but what in the future the roentgenologist will be able to interpret an emergency roentgenogram from his fireside or weekend cabin. True to the name, he can become a radiologist and practice modern medicine via radio—it is interesting to speculate upon.

EARLY STUDIES IN AMERICA

It would appear that credit for the first roentgenogram for medical diagnosis to be made in this country belongs to Michael Pupin, who examined a case of multiple gunshot wounds of the hand, and his efforts to reduce the exposure time of one hour by interposing a piece of fluorescent cardboard is the first application of the principle of the intensifying screen. Because the phenomena of fluorescence was associated with the discovery of x-rays, much experimentation was carried on with possible fluorescent substances. The most original and lasting experiments were carried out by Edison, who examined over 1,800 combinations and discovered that the fluorescence of calcium tungstate crystals has about six times more intensity than barium platinocyanide. He recommended, in March, 1896, the use of this salt for fluoroscopic screens. Concurrently he invented the fluoroscope, which consisted of cardboard upon which calcium tungstate crystals were retained in position by a matrix of collodion. This was inserted in a truncated pyramidal box, in which handles were attached on one side. The open narrow curved end was shaped to fit closely over the forehead and eyes, and lined with black feathers to prevent eternal light, while the observer watched the shadows on the screen at the other end. Edison, in his enthusiasm, said, "with the fluoroscope the surgeon should be able to determine in a moment, in case of a number of shot, just where the bullets have lodged and operate accordingly. There is no occasion to take photographs, shadowgraphs or radiographs." The localization of foreign bodies became a current problem, and this was greatly aided by Elihu Thompson who, in 1896, applied the principle of stereoscopy to roentgenology. With refinement in the location of foreign bodies came an increased interest in the recognition of bone-fractures and lesions about joints. These observations, and especially those of Wilbert, were the beginning of the inseparable relation between orthopedic surgery and roentgenology.

X-RAYS AND INTERNAL MEDICINE

Williams predicted the value of x-rays to the internist in April, 1896, when he gave an account of the first medical case examined by him, a chest, in which the fluoroscopic outline of an enlarged heart "corresponded, in a general way, to the outline drawn on the skin with percussion as a guide." Within a year he had reported extensively on his observations in thoracic disease, and in 1898, he recorded his observations in nearly every circulatory and respiratory condition of the chest known to the internist of that time. He is credited with having been the first to use an opaque meal in the human and, working with Cannon in 1899, Williams made many important contributions to the knowledge of the physiology of digestion. In 1901 Williams published his textbook, "Roentgen Rays in Medicine and Surgery," the first significant book to appear in this country on the clinical application of the x-ray. The application of x-rays in medicine even in that time had become so ramifying that, for the sake of some orderly discussion, it is best to consider them under separate headings.

GASTRO-INTESTINAL TRACT

Cannon's classic fluoroscopic studies of the alimentary mechanism of the cat, and his subsequent observations with Williams in 1899, on humans, were the beginning of a method of studying the alimentary tract that has revolutionized the practice of gastroenterology, or indeed has made such a specialty possible. In the field of gastrointestinal roentgenology, the names of three American roentgenologists—Cole, Carman and Case—stand out.

To Cole must go the credit for establishing the present criteria for the diagnosis of duodenal ulcer on the basis of direct evidence or deformity of the duodenal cap.

Carman pioneered in the study of gastric lesions, and his observations on the changes associated with early cancer of the stomach are classic. Through his efforts concerning the early diagnosis of this disease, much of present-day surgery of the stomach has been made possible. Later he contributed largely to roentgenologic knowledge of the appearance of the postoperative stomach and gastro-jejunal ulcer in particular. It is a tragic coincidence that he himself was a victim of the disease that he had tenaciously sought to elicit in his fellow men.

Case's important work on the ileum and colon, especially in connection with (a) lesions beyond the first portion of the duodenum, (b) ileal stasis and its causation, and (c) multiple diverticulae of the colon, was the beginning of the modern roentgenologic examination of the colon.

Through the passage of time additional techniques have been perfected, the two most significant being the development of mucosal relief studies, or "spot roentgenography," as initiated by Forsell, and the introduction of the double contrast method of examining the colon so ably developed by Fischer and later by Weber. The use of these

procedures has enabled the roentgenologic demonstration of minute lesions of the intestinal tract not heretofore thought possible. Of particular significance is the advance made during the past five years in the diagnosis of lesions of the small bowel, and the demonstration of changes in the intestinal tract that are associated with deficiency diseases.

PULMONARY LESIONS

Williams' original observations stimulated the use of the x-rays as a means of recognizing pulmonary tuberculosis in the earliest stages. Because of its limitations and the lack of detail of the resultant image, the fluoroscopic examination of the chest soon gave way to the x-ray plate in the search for early tuberculosis. The improvement in intensifying screens, and particularly the development of the x-ray film by Eastman to replace the cumbersome glass plate, opened the field of chest diseases more widely than ever. Coolidge, by the introduction in 1913 of the hot cathode tube, made possible exposure control and a uniformity of results, two conditions long desired in chest roentgenology.

Further refinements in technical methods effected the development of two important fields of medicine: (a) tuberculosis surveys; and (b) thoracic surgery, the newest stepchild of surgery. Neither of these would be possible without the discerning eye of the x-ray. During the past decade, the introduction of photofluorography has widened the use of x-rays in tuberculosis survey work. In this connection the important investigations of Potter, which enabled the perfection of the 4 x 5 photofluorogram, should not pass unmentioned. In spite of the fact that the merits of the 35mm. photofluorogram vs. the 4 x 5 size are still subject to debate, it still remains that this method, which permits the survey of the chest of large masses of population at great economic saving, will be permanently reflected in improvement of health throughout the country as pertains to pulmonary tuberculosis. The present experience of the army and the navy with the procedure will be of inestimable value in determining its postwar applications. That it has thus far been a true life saver in screening certain unsuitable candidates from military life, is not to be denied. The perfection of body section roentgenology—commonly referred to as tomography or laminography—has been curtailed by the necessities of war, but it has already added much to our roentgenologic knowledge of pulmonary and laryngeal lesions.

SKELETAL SYSTEM

The early application of roentgen rays to the study of the skeletal system was limited largely to the detection of fractures, in which the fluoroscope played a major rôle. With the gradual abandonment of the fluoroscope in favor of the x-ray plate, certain minor lesions clinically undeterminable, or even unsuspected, were frequently recognized. Indeed the so-called "x-ray fracture" became an entity in clinical terminology. Hickey's observations in 1904 concerning the development of the skeleton was the beginning of the application of roentgenologic methods to the teaching of osteology. By its ease of application to large amounts of material, the data obtained from rapidly accumulating x-ray studies necessitated the change of much data in anatomical texts. Our knowledge concerning bone tumors was meagre enough before the introduction of x-rays, and because of information resulting from numerous roentgenologic observations it became necessary to entirely change the classification of bone tumors. Today many a skillful pathologist will ask to observe the roentgenogram when studying the tissue from a suspected neoplasm of bone. That roentgenology has made the development of orthopedic surgery possible, is a well-known fact. While the early decades of roentgenology were concerned chiefly with isolated or solitary lesions of the skeletal system, the past score of years have afforded an understanding of generalized disease of the skeletal system, especially such as may be concerned in systemic diseases. Skeletal surveys of large groups of children undertaken by various foundations, or sponsored by various endowments, have yielded much significant data concerning the normal development of our children. The importance of this far-reaching program is probably not as yet fully appreciated.

BILIARY TRACT

Buxbaum, in 1898, was the first to report the observation of a gallstone in a living subject. Numerous similar reports by other workers followed, but it was soon established that the roentgenographic demonstration of gallstones depended on the calcium content of the stone; and since that is quite variable, the practicability and reliability of the x-ray demonstration of biliary calculi was tempered with much pessimism. In 1910 renewed interest in gallbladder diagnosis was stimulated by Schurmayer's observations concerning displacements and fixations of the paracholecystic structures produced by adhesions, and in 1911 Pfahler stated that the roentgenographic demonstration of pericholecystic adhesions was of even greater importance than the search for gallstones. Further technical improvements enabled George and Gerber to express the belief that stones could be demonstrated in nearly all cases of gallbladder disease when stones are present. George and Leonard, in 1917, pointed out that any gallbladder casting a roentgenographic shadow was abnormal. Their observations did not go unchallenged, but they did have many enthusiastic supporters. The greatest and outstanding contribution to the x-ray diagnosis of cholecystic disease was made by Graham, Cole, Copher and Moore in 1924, when they introduced intravenous cholecystography. In 1925 the oral administration of sodium tetraiodophenolphthalein was advocated by Menees and Robinson. The efficacy of each method developed, month by month, and each con-

tinued to have its supporters. By the end of that decade the reliability of the oral method was firmly established; and except for the later addition of the double-dose method, it has remained essentially unchanged until the present. From the standpoint of cholecystic diagnosis, cholecystography performs the service of a functional test, an index of the presence of gallstones and an indicator of the size, contour and position of the gallbladder.

URINARY TRACT

The ease with which the x-rays revealed foreign bodies stimulated an early interest in the search for urinary calculi. As early as 1896, for example, MacIntyre demonstrated in a living subject, after an exposure of twelve minutes with a six inch spark coil, the presence of an intrarenal concretionary mass. Contrast this with present-day techniques that portray intrarenal calculi with fractions of a second exposures, and with a wealth of detail that was little dreamed of in earlier days. In 1897 Tuffier made the first attempt to render the urinary tract opaque to roentgen rays by introducing a radiopaque catheter into the ureter. In 1906 Voelcker and von Lichtenberg demonstrated the outline of the ureter and renal pelvis by means of colloidal silver and thus laid the cornerstone of pyelography, a procedure that was rapidly carried to perfection by its originators and others. It remained for Rowntree, Sutherland, Osborne and Scholl, in 1923, to introduce the procedure of intravenous urography by means of sodium iodide. This procedure was brought to perfection by von Lichtenberg and Swick in 1929, when they introduced a less toxic and more radiopaque substance, "uroselectan." In addition to its direct function as a contrast medium, the substance also serves as an indicator of renal function. It might be said that the value of urography to the urologist is of the same magnitude as the value of the barium examination of the gastro-intestinal tract to the gastroenterologist.

NEUROLOGIC DIAGNOSIS

The early attempts at roentgenologic examination of the skull were disappointing and discouraging, because of many technical difficulties to be overcome, and the problem of differentiating the various structures involved. Even Schuller, the pioneer neuroroentgenologist, as late as 1917, stated that the problem of differentiating tissue changes within the shadow of the superimposed skull requires the wisdom of experience to realize that only occasionally can such information be obtained directly. The demonstration of fractures of the skull, and studies of the mastoids and nasal accessory sinuses, were the chief centers of interest to the roentgenologist of that era. Concurrent with this period was the evolution of neurosurgery, and its requirements for a more precise localization of brain tumors brought about the introduction of ventriculography by Dandy in 1919. This was followed, in a few months, by his report on the procedure of encephalography. Both of these procedures, which are essentially unchanged today, have made possible many of the triumphs of the neurosurgeon. With the exception of demonstrations of malignant lesions of the vertebrae, the roentgenologist added little to the recognition of tumefactive lesions affecting the spinal cord until Sicard and Forrestier, in 1922, reported on the use of lipiodol injected into the spinal subarachnoid space as a means of localizing tumors within the spinal canal. The rapid development of neurosurgery during this period provided a stimulus for the use of intraspinal lipiodol, and experience soon revealed that this procedure enabled a precise localization of the lesion that had long been desired. Despite later and more recent attempts to replace it by other contrast agents, lipiodol still remains the agent of choice for the early recognition and precise localization of intraspinal lesions. Only through the means of contrast myelography has the present-day approach to the problem of the protruded intervertebral disk been made possible.

THERAPEUTIC ROENTGENOLOGY

The story of the development of the use of the roentgen rays for the treatment of disease is one that in itself would fill a good-sized volume. It is a narrative that more closely concerns our honored guest, than any other part of the romantic development of the science of roentgenology. In this field Doctor Soiland has been an outstanding pioneer, and through his researches and constant desire to attain perfection in the treatment of cancer and allied diseases, he has contributed much, as other speakers have told you.

Very shortly after Roentgen's discovery, many experimenters throughout the world were busy investigating the photographic and fluoroscopic applications of the x-rays. The exposures were long, the dangers unknown and skin effects were soon evident. Hearing of the observance of the falling out of the hair on the scalp of a patient who had had his skull "photographed with x-rays" a Viennese physician, Freund, conceived the idea that their epilating effect might be useful in the treatment of certain skin lesions. The report of his successes was the spark that stimulated other physicians to investigate the therapeutic properties of this new kind of ray. The early equipment was crude, and the dosage was uncontrolled. Studies on the biologic effects of the x-rays stimulated efforts to modify and control the effects, and brought about the first suggestion for filtration of the rays, and some form of unit for measuring dosage. In the earliest days of x-ray treatment only skin diseases and some superficial malignancies were treated. Cancer of the breast, because it was superficial, was one of the first malignant conditions treated.

Since 1910 neoplastic diseases in all parts of the body have been treated by x-rays. With improvements in apparatus, the use of filtration and greatly extended observations and experiments, it

was possible to demonstrate better results in the treatment of deep-seated lesions. Concurrently physical researches on wave length and intensity yielded a profound influence on the development of therapeutic roentgenology. The crowning achievement was the establishment of an international unit of dosage, the "roentgen," at the meeting of the International Congress of Radiology in 1928. At this stage x-ray apparatus was again suffering from growing pains, and the antiquated spark coil and conventional transformer gave way to high voltage transformers of 200,000 volts' capacity. The clinical results with higher voltages encouraged the development of machines of still greater capacity, and the introduction of supervoltage. Most recently, we hear of megalavoltage machines of 20,000,000 volts, and future developments are interesting to speculate about. Certainly through the intense coöperation of the physicist, the x-rays have unleashed untold potentialities for research in the treatment of disease.

INDUSTRIAL APPLICATIONS

In our casual acceptance of the commonplace medical applications of the roentgen rays we are apt to lose sight of the fact that industry has not been slow to adopt the use of this uncanny "physical detective." The development of the use of x-rays in industry is as romantic a story as the development of the applications of x-rays in medicine. So great has been the expansion of this field of roentgenology that it already overshadows the medical aspect, and new applications for it are unfolded daily. As an x-ray film reveals flaws and disease in the human organism, so it also reveals the flaws and disease in the inanimate things of our every-day life. As a consequence, we may build a better airplane, cannon, skyscraper, rubber tire or most anything that the present-day scientist may direct.

EDUCATIONAL

In the orderly development of any science there is engendered in those who toil at its building a spirit of argument, debate and coöperation. This is reflected in the organization of groups or societies for the collective discussion and exchange of ideas and theories. The first organized x-ray society in the United States was founded in 1900 as the Roentgen Society of the United States. Later, the same year, its name was changed to the American Roentgen Ray Society, and as such it has continued an unbroken activity until the present. This was predominately an Eastern organization, and in 1915 the Western Roentgen Society was formed. On the west coast Doctor Soiland founded the Pacific Coast Roentgen Ray Society, and thus began his historic contributions to the cause of organized radiology. In 1920 the Western Roentgen Society was reorganized as the Radiological Society of North America. This democratic society has exerted a powerful influence on the scientific development of roentgenology ever since. As early as 1922 Doctor Soiland, who had fostered the embryonic phases of this organization, was elected to its presidency. Radiology was now clamoring for recognition as a specialty of medicine, and at this time Doctor Soiland, a member of the House of Delegates of the American Medical Association, presented a resolution to that body requesting the formation of a Section of Radiology in the American Medical Association. Concerning this action of Doctor Soiland's, it has been said that "he has done more than any other one influence to give the radiologist a standing in organized medicine." In June, 1923, Doctor Soiland founded the American College of Radiology and became its first president. This organization, composed of the outstanding leaders in the specialty, has become the mouthpiece for organized radiology in this country, and has fostered the organized postgraduate training of physicians in the specialty. In September, 1933, the American Board of Radiology was founded, and through its offices standards and requirements for training in radiology are determined.

Thus in a span of forty-eight years—a short time, to be sure, in the history of science—there has developed about the discovery of a new kind of ray a complete new science in itself: one so great and with ramifications so profound that it is destined to enrich civilization for generations to come. From the feeble fluorescence of Roentgen's experiment, there has ensued a light so revealing, and so intense, that its significance can only be comprehended by a realization of the scientific chaos that would surround us if that light were suddenly to fail.

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DIVERTICULOSIS AND DIVERTICULITIS OF THE COLON*

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TWENTY-FIVE years ago, the diagnosis of diverticulosis and diverticulitis was a roentgenological and anatomical curiosity. Today, under the modern roentgenologist and clinical interpretations of the signs and symptoms, the diagnosis is common and the anatomical study shows that it occurs in a large percentage of the general population after the fourth decade of life. In a routine series of 1,000 cases of barium enemas, Spriggs and Marxer[16] found ten per cent of the cases had diverticulosis. The first to write on the subject in this country was Beer in 1904. The first report of surgical treatment was by W. J. Mayo, Wilson and Giffin[11] when they reported five surgical cases in 1907. Moyniham[14] was the first to write on diverticula and its relation to malignancy of the colon. Rankin[15] reported the

* Read before the General Meeting, at the Seventy-first Annual Session of the California Medical Association, Del Monte, May 5-8, 1941.

study of 227 cases and only found four cases of malignancy, and refuted the theory, that there was a definite relationship between diverticulosis and malignancy. Judd[7] wrote many manuscripts on this important subject and reported 188 cases with 75 per cent in the sigmoid colon. There have been many other contributors on the subject and the literature is voluminous.

These cases occur in the fourth, fifth, sixth, seventh, and eighth decades of life, but many cases have been reported much earlier. Karsner,[8] in twenty years' experience in the roentgenology department of the Los Angeles Children's Hospital, has never seen a single case from the roentgenological findings. The diverticula occurs more frequent in the male than the female, about in the ratio of two to one. They occur along the mesenteric border of the bowel and in close relationship to the blood vessels. This theory, as regards the etiology, belongs to Klebs. There is a defect in the longitudinal muscle fibers, and this makes for a predisposition for diverticula formation. The first roentgenological report of diverticula was in 1914. There are many contributory conditions, such as obesity, constipation, flatulency causing increased gas pressure and advanced age. Lunding[10] believes they are caused by the Catalase action in the feces. Like many other conditions we do not know the exact etiology of, this condition and the causes remain obscure.

In a study of 500 autopsies which consisted of 364 men and 136 women in which the cause of death was not known until autopsy examination was made, diverticulosis was found in 26 cases or 5.2 per cent. There were 20 men and 6 women. The age incidence was as follows:

20-30	2 cases
30-40	70 cases
40-50	115 cases
50-60	158 cases
60-70	121 cases
70-80	34 cases

SYMPTOMS

These patients usually complain of a dull aching pain in the lower half of the abdomen, and especially the lower left quadrant, the pain is aggravated by cathartics and then the pain becomes cramp-like. Along with the pain are the other symptoms and findings of an acute abdomen depending on the stage or amount of inflammation. Tenderness exists in almost all cases. Rigidity present if inflammation present, temperature from a fraction to several degrees, leucocytosis, constipation, vomiting, tumor formation depending on the degree of the pathological process. There may be present abscess formation, perforation, peritonitis, and obstruction of the bowel. In a larger percentage of cases, the inflammation subsides before the advanced stages of complications takes place.

DIAGNOSIS

The diagnosis can usually be made by following a definite procedure of taking a detailed history, finding out that the attacks were present for some time, and pain in the lower left or lower half of the abdomen. Usually occurs in normally healthy obese individuals in the fourth, fifth, sixth, seventh decades of life. These patients in most instances otherwise are in good general health. The leucocytosis will vary from 10,000 to 30,000 depending on the pathological condition present. Tenderness is present in a larger percentage of the cases. There may or may not be any temperature elevation depending on the stage of the inflammation. If repeated attacks or abscess formation, a palpable tumor may be found either by palpation of the abdomen or by rectal examination. In a very high percentage of the cases the barium enema will show the diverticula, in some cases it will be necessary to repeat the barium enema several times before the diverticula will be demonstrated. Also the barium enema shows a large percentage of diverticula that are nonsymptomatic in character. The sigmoidscopic examination is very helpful in most cases. If perforation or fistulous communication with urinary bladder exists, the cystoscopic examination is of great importance in making the diagnosis.

DIFFERENTIAL DIAGNOSIS

Diverticulosis and acute diverticulitis must be differentiated from sigmoiditis. This can usually be done by a sigmoidscopic examination and barium enema. Carcinoma must be ruled out where the condition has existed for some time, and peridiverticulitis is present with some or complete obstruction. Usually the rapid increase in constipation, loss in weight, strength, appetite, diarrhea, blood in stools, aid of the barium enema will differentiate between the two conditions. If peridiverticulitis exists and complete obstruction is present, in some instances only a laparotomy will differentiate and then it might be difficult in some cases. Peridiverticulitis usually exists over a period of many years, with repeated attacks of pain, tenderness, and increasing constipation.

Lues is mentioned as a possibility, but lues occurs much less frequent, and other luetic findings would be present along with a positive Wassermann and spinal fluid examinations. The barium enema would not reveal any diverticula.

Pelvic inflammatory mass can be ruled out by careful history, clinical examination, clinical findings, and no diverticula with the barium enema.

Stone in the left ureter should be ruled out by x-ray of the left kidney, ureter, bladder, examination of the urine, and the type and character of the pain present.

The two most frequent conditions taken for acute or subacute diverticulitis, are acute appendicitis and ruptured duodenal ulcer. The most common diagnosis made for acute diverticulitis is acute appendicitis, and a barium enema is one of the only ways to rule out acute appendicitis. With duodenal ulcer, usually one can get a history of the character of the pain, location of pain,

food or soda ease. In acute cases where this is not possible, only the provisional diagnosis of an "acute abdomen" can be made and surgical intervention advised.

METHODS OF TREATMENT

Ambulatory treatment can be carried out, if there is no or slight elevation of the temperature, no increase in the leucocyte count, no nausea, vomiting, and evidence of perforation. The patient should be placed in bed, nothing by mouth for 24-48 hours, ice bags to the lower abdomen, or hot water bottle or dry heat. Rectal irrigations, using warm normal saline. After the inflammation subsides liquid petrolateum or metamucil number two by mouth. The diet to start should be as nearly residue free, as possible, for several days or weeks. One should go sparingly, after the inflammation has subsided, with red meats, potatoes, milk, foods containing seeds, foods with too much fibre, and foods forming too much bulk, and those which increase bacterial activity in the large bowel. The lower bowel should be evacuated each day and some mild antiseptic enema given, oil retention enema at night time to be retained during the sleeping period. Most patients will do well under this régime if they continue to carry out the treatment.

SURGICAL INTERVENTION

If there is severe pain, high leucocyte count, tenderness, rigidity, evidence of perforation, or abscess formation, surgical intervention is indicated immediately. In spite of medical treatment these complications take place. If one encounters an abscess, then drainage is indicated. If obstruction, a cecostomy is indicated. If the signs and symptoms present are those of an acute abdomen and a definite diagnosis of abscess, and perforation or obstruction cannot be made, surgical intervention may be indicated. The patient should be treated the same as in any other acute abdominal condition. Bed rest, Fowlers' position, morphine sulfate, intravenous glucose, 5 or 10 per cent as indicated, dry heat to the abdomen, and sometimes diathermy. The surgeon will be guided by the pathology found at the time of operation. In a large percentage of cases, the diagnosis will not be made only with the aid of the barium enema, and the clinical diagnosis will be either acute appendicitis or ruptured duodenal ulcer. In the female one must keep in mind pelvic cellulitis, pelvic abscess, and ectopic pregnancy.
(?) *Author to clarify last sentence.*

METHODS OF SURGICAL INTERVENTION

After the diagnosis has been made, or the diagnosis of an acute abdomen has been made, the surgeon is confronted with what surgical procedure to carry out and many methods of attack are given:

1. Freeing of adhesions to the small bowel and female pelvic organs.
2. Drainage of the abscess.
3. Suture of the perforation.
4. Resection of the colon.
5. Resection of the fistulous communication with the urinary bladder, bowel, and ovary.
6. Colostomy.
7. Cecostomy.
8. Ileosigmoidostomy.

Following any one of these surgical procedures, the patient is going to have a stormy convalesence, as either peritonitis or obstruction will be present and this adds to the mortality. Diverticulosis and diverticulitis will always present difficult problems to the patient and to the doctor, both from the medical and surgical standpoint. We must, therefore, be ever on the watch for diverticulosis in patients with dull aching pain in the lower half of the abdomen, and demand strict medical régime so as to prevent surgical complications, as much as possible. Complications, developed from 7-10 per cent and from 10-20 per cent, require surgical intervention.

REPORT OF CASES

Case 1.—Mr. A. G., male, age 49, special deputy sheriff, married, no family. Personal and family history essentially negative. No serious accidents or operations. Chief complaint, acute pain in the epigastrium with nausea, vomiting. Ill April 6, 1931. History of soda and food ease, repeated attacks. Temperature 102. Pulse 120, respirations 22, blood pressure systolic 168, diastolic 112. Sent to hospital April 6, 1931. Leucocyte count 20,000 April 7, 1931. Leucocytosis 18,400. Lower left abdomen more tender and rigid. Hemaglobin 70 per cent, urine negative, April 8, 1931. Barium enema showed diverticula lower descending colon with extrensic mass displacing the colon toward the midline, mass smooth in outline very tender on palpation, April 10, 1931. Operation revealed a large abscess, drained, convalescence stormy, recovered, had fecal fistula for about one year. Placed on smooth diet, oil by mouth, daily evacuation of bowel, no trouble since.

Case 2.—Mrs. R. P., female, age 76, widow, housewife. Pneumonia, 1927. Present complaint diarrhea, cramps, rapid pulse, weakness, loss in weight onset, February, 1931. Lower left abdomen tender on palpation. No tumor palpated mass. Rectal, no palpable mass. Vaginal old cervical laceration. Hemaglobin 50 per cent, leucocyte count 7,600 red blood cells 3,800,000, urine negative. Barium enema reached the sigmoid and encountered obstruction, diverticula present. Belladonna given barium enema repeated, obstruction still existed diagnosed as multiple diverticulosis with obstruction of the sigmoid colon. Sinus tachycardia. Exploration revealed large mass in the sigmoid colon. Mikulicz resection done, patient died ten months later of carcinoma and multiple diverticulosis.

Case 3.—Mr. P. B., male, age 42, married, salesman. Appendectomy, 1926. Present complaint, acute pain in the lower half of the abdomen, two days' duration. Nauseated, no vomiting. Had same type of attacks before appendectomy and after the operation. Always conscious of dull aching pain in the lower abdomen. Bowels inclined toward constipation. Well developed, fat male, tenderness and rigidity of the lower half of the abdomen. No palpable tumor mass, leucocyte count 23,200, hemaglobin 84 per cent, polymorphoneuclars 86 per cent, urine negative. Barium enema shows multiple diverticulosis

lower descending colon with obstruction of the colon in the sigmoid. Diagnosis diverticulosis with abscess formation and obstruction. May 11, 1933 exploration was done. A large irregular mass was encountered in sigmoid colon. On account of age, no loss of weight. A caecostomy with drainage was done. Following drainage the mass and the obstruction cleared up, and the caecostomy closed itself. Patient has been well since. Follows diet and ambulatory treatment closely.

* * *

Case 4.—Mr. P. S., male, age 46, married, oil field engine man, strong, fat, robust male. Operation for chronic right olecranon bursitis, 1939. Repair of left inguinal hernia and second repair in 1924. Present complaint acute pain in lower left abdomen, requiring morphine sulfate grains one-half and sedative by mouth six grains. Tenderness and rigidity lower left abdomen with nausea, no vomiting. X-rays of the kidneys, ureter, and bladder negative. Barium enema shows obstruction in the lower descending colon with diverticulosis. Leucocytosis 15,400. Urine negative. Diagnosis of multiple diverticulosis with obstruction of the lower descending colon. Exploration revealed peridiverticulitis. Caecostomy with drainage was done and one year later obstruction was relieved. Ambulatory treatment carried out, and patient is working hard each day in oil field and general health is good.

COMMENT

Diverticulosis and diverticulitis is a common condition, existing in a large percentage of the general population, 5-15 per cent. About 5-10 per cent develop complications, and 12-20 per cent require surgical intervention. These diverticula do not exist at birth, occur in the fourth, fifth, sixth, and seventh decades of life. They are produced by many extraneous factors, such as obesity, constipation, flatulency, weakness in the longitudinal muscles fibers of the colon, and many others that we know very little about. Most patients can be well-handled on a smooth diet, high caloric in value for needs, enema to keep lower bowel evacuated, and Metamucil number 2, mineral oil, or any other soft oily preparation by mouth. These patients must always watch their diet and be educated to watch for anything that might develop in the way of complications. After the diverticula once develop, there is no way of eliminating them unless only a single diverticula exists, which can be excised. Resection of the color or the area involved may give good results.

1052 West Sixth Street.

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Infantile Paralysis.—The National Foundation for Infantile Paralysis and the University of Michigan have joined in a long-range program for the training of doctors, public health workers and laboratory technicians to study infantile paralysis and other virus diseases.

This program, which has been developing for three years, will be expanded to its full scope about June 1 when the University opens its new three-story building for its School of Public Health at Ann Arbor, Mich.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL NOTICES

HOUSE OF DELEGATES: FIRST MEETING

Minutes of the Fortieth (40th) Annual Session of the House of Delegates of the California Medical Association

Held at Hotel Biltmore, Los Angeles, California
Sunday, May 2, and Monday, May 3, 1943

First Meeting, Sunday Noon, May 3, 1943, in the Music Room, Hotel Biltmore

The first meeting of the fortieth session of the House of Delegates of the California Medical Association, at the seventy-second annual session, held in Hotel Biltmore, Los Angeles, California, was called to order at 12:00 o'clock noon, Speaker Lowell S. Goin, presiding.

* * *

SPEAKER GOIN: The House will be in order. The first order of business is the temporary report of the Credentials Committee (Edward S. Babcock, of Sacramento; S. A. Jelte, of Oakland; and Eugene F. Hoffman, of Los Angeles).

The Chair recognizes the Chairman of the Committee on Credentials, Dr. Hoffman of Los Angeles.

DR. EUGENE F. HOFFMAN (Los Angeles): Mr. Speaker, your Credentials Committee reports that there are 48 qualified delegates seated. I move that the report be adopted.

The motion was seconded, put to a vote and unanimously carried.

SPEAKER GOIN: The Committee's report is adopted, and it is so ordered.

Mr. Secretary, is there a quorum present?

SECRETARY KRESS: Mr. Speaker, a quorum is present.

SPEAKER GOIN: The provisions of the Constitution and By-Laws have been complied with. I now declare the House duly constituted and open for such business as may lawfully come before it.

The purpose of convening at twelve o'clock is to comply with the provisions of the Constitution. It demands at least two meetings of the House of Delegates during an Annual Session, and that these two meetings be separated by 24 hours. You will need to have lunch, so it is our intention to now recess the House, to reconvene at 1:30. The Chair will entertain a motion to recess until 1:30 P. M.

DR. JOHN W. CLINE (San Francisco): I move we recess until 1:30 P. M.

DR. KARL L. SCHAUPP (San Francisco): I second the motion.

The motion was put to a vote, and it was unanimously carried.

SPEAKER GOIN: The House stands recessed until 1:30.

At 12:15 P. M. the House recessed, to reconvene at 1:30 P. M.

The House of Delegates reconvened at 1:30 P. M. in the Music Room of the Biltmore Hotel, Speaker Goin presiding.

Post-Recess Meeting

SPEAKER GOIN: The House will again be in order.

The purpose of receiving a supplemental report of the Credentials Committee is to determine if there is a

quorum present. The Chair recognizes the Chairman of the Committee on Credentials, Dr. Hoffman.

DR. HOFFMAN: Mr. Speaker, your Committee on Credentials reports that 48 qualified delegates have been seated.

I move that the report be accepted as the Roll Call of this Body.

DR. EDWIN L. BRUCK (San Francisco): Second the motion.

SPEAKER GOIN: It has been seconded by Doctor Bruck that this is the Report of the Credentials Committee, and the Roll Call of the House. Is there any discussion?

There being no discussion, the motion was put to a vote and was unanimously carried.

SPEAKER GOIN: It is carried and so ordered.

Reference Committees

The Reference Committees of the House appointed by the Speaker are as follows:

(a) Committee on Credentials:

Dr. Edward S. Babcock, Sacramento.
Dr. S. A. Jelte, Oakland.
Dr. Eugene F. Hoffman, Los Angeles, Chairman.

(b) Reference Committee on the Reports of Officers and Standing Committees (Reference Committee No. 1):

Dr. Deon A. Crew, San Luis Obispo.
Dr. H. D. Neufeld, Contra Costa County.
Dr. J. Frank Doughty, Tracy, Chairman.

(c) Reference Committee on the Report of the Council and the Report of the Secretary-Treasurer (Reference Committee No. 2):

Dr. James C. Doyle, Beverly Hills.
Dr. E. C. Halley, Sanger.
Dr. W. H. Geistweit, Jr., San Diego, Chairman.

(d) Reference Committee on Resolutions, Amendments to the Constitution and By-Laws, and New and Miscellaneous Business (Reference Committee No. 3):

Dr. John Hunt Shephard, San Jose.
Dr. Thomas A. Card, Riverside.
Dr. Samuel Ayres, Jr., Los Angeles, Chairman.

The time and place will be announced later.

* * *

We come to the Report of the Council, Dr. Philip K. Gilman, Chairman, which is contained in the printed reports.

Next are the Reports of the Auditing Committee, the Secretary-Treasurer, the Executive Secretary, the Editor, the District Councilors and Councilors-at-large, and the Report of the Chairman of the Department of Public Relations, all of which have been printed in CALIFORNIA AND WESTERN MEDICINE.

If there is no objection on the part of the House, we will save a great deal of time by simply referring these to the proper committees without taking your time to read them. If there is no objection, the Reports of the Auditing Committee, the Executive Secretary, the District Councilors and the Councilors-at-large will be referred to Committee No. 1.

The Reports of the Council and Secretary-Treasurer and the Editor are referred to Committee Number 2.

* * *

The next item of business will be the Report of the General Counsel, Hartley F. Peart, Esquire.

Report of General Counsel, Hartley F. Peart

LEGAL COUNSEL PEART: Mr. Speaker and Members of the House of Delegates: Time is precious today and I am only going to attempt to report briefly on the status of the Association's application to the Industrial Accident Commission for a revision of the fee schedule in compensation cases. The new schedule compiled by the Committee appointed by the Council, consisting of Dr. Donald Cass, Chairman, Dr. Frank A. MacDonald and Dr. Carl L. Hoag, assisted by the Executive Secretary, John Hunton, covers 547 procedures and operations against 87 in the present schedule. That is a very extraordinary statement, but it is a fact. The present schedule of the Industrial Accident Commission covers only about 87 procedures and operations. The new proposed schedule raises home, office and hospital visits about 50 per cent, and operations and procedures about 25 per cent over the existing schedule. It has been approved by Dr. Harbaugh, Medical Director for the Commission.

The existing schedule became effective June 1, 1920, nearly 23 years ago. The Commission held a public hearing on February 15th last. Captain Philip K. Gilman, Chairman of the Council, Mr. Hunton and members of the Committee were in attendance, prepared to testify, but the Commission said they did not wish to hear testimony. At the hearing, on behalf of the Association, it was pointed out that no fees had ever been fixed on over 450 operations and procedures; that the present scale for operations and procedures covered was inadequate and unfair to the injured workmen, and that in the intervening 22½ years, compensation under the Act had been increased and benefits enlarged; that employment had greatly increased with a corresponding increase in this practice; that medical practice had made great advances in diagnosis and treatment, and that the injured workman is today receiving far better care with better results than 22½ years ago; that costs to the doctors for education, equipment, maintenance, practice and living have greatly increased; that wages have increased, but that compensation rates have declined.

We found that the reports of the insurance companies filed in the office of the Insurance Commissioner showed that dividends were being paid shareholders by stock companies, and refunds were being made to members of mutual companies out of premiums paid for compensation insurance, and the records of the Commission itself, which I personally examined, showed that the State Insurance Compensation Fund had for years been rebating millions of dollars to its policyholders.

There was a large attendance at the hearing. Representatives of associations of insurance companies appeared by counsel. Self-insurers were in attendance. No direct opposition was voiced by anyone except the State Compensation Insurance Fund, by one of its attorneys, who stated that it was opposed to the application. Representatives of insurance companies urged that there be a study of statistics, one of them stating that the Commission was somewhat new and inexperienced. We urged that the primary purpose of the Compensation Act as stated in the Constitutional Amendment was based on medical care to the injured workman, and that compensation insurance is secondary.

The Commission took the matter under consideration. A few days ago we received a letter from the Secretary of the Commission advising that, in view of the pendency of Assembly Bill 292 and Senate Bill 1097 in the Legislature (which bills I thought would have been described to you by Dr. Murray, Chairman of the Legislation Committee), the Commission would defer further consideration of the application until the Legislature adjourned. As Dr. Murray has not spoken, I will say that AB 292 was introduced by Assemblyman Gaffney and some of his associates, all of whom are very friendly

to Labor. This bill provided, in effect, that rebating from the Industrial Accident Commission's fee schedule would constitute a misdemeanor and would prohibit it.

We took this bill and added three amendments, which provided that the rebating or fee-splitting or cutting with insurance companies under the fee schedule established by the Commission, should constitute grounds for revocation of the license of the insurance company engaged in this practice; that it would constitute a felony by anyone violating any of its provisions, and that any agreement by an insurance company or by an employer for the furnishing of medical or hospital care to injured workmen, must be filed with the Commission within five days after it is made and, unless approved by the Commission within 30 days thereafter, should be void and of no effect.

These amendments were accepted by the Labor representatives and were embodied in AB 292. Dr. Murray and Dr. Reed reported, however, that the conditions were such with reference to the Assembly Committee on Insurance, where the bill had been referred, that there was very little likelihood of our obtaining any action whatsoever upon the bill. We, thereupon, secured the introduction of the bill with the amendments in the Senate, through the courtesy of Senator Burns of Fresno where, with some active work on the part of some of our Labor friends, the bill was referred to the Labor Committee of the Senate. Our representative at Sacramento was subsequently advised by our friends in the Labor ranks that they had made an agreement for the enactment of some other measures, and that under the terms of this agreement, they would be compelled to oppose the passing of this bill. Our representative there felt that under these circumstances it was useless for us to try to do anything further at this session.

The members of the Commission and its officers have been most courteous and attentive throughout the proceedings.

Thank you. (Applause.)

SPEAKER GOIN: The Report of the General Counsel will be referred to Committee No. 1.

* * *

With the consent of the House, the Chair will now refer all agenda items under Number 13, *Reports of Standing Committees*, to Reference Committee Number 1.

Under *Special Committees* we come to the reports on the Committee on Public Health Education and the Committee on Medical Benevolence. These have both been published, and we will refer them to Reference Committee Number 1.

DR. AXCEL E. ANDERSON (Fresno): That was just a preliminary report rendered by the Committee on Physicians' Benevolence. I have here a further report.

SPEAKER GOIN: The Chair recognizes Dr. Anderson, Chairman of the Committee on Physicians' Benevolence.

Reference Number 1: (See 6, 39 and 41.)

Report of Committee on Physicians' Benevolence

DR. AXCEL E. ANDERSON: Mr. Speaker, Members of the House: As reported in the "Pre-Convention Bulletin," the amendment to the By-Laws of the California Medical Association to permit the allocation of one dollar per active member from the annual dues to the Benevolence Fund was defeated at a meeting of the House of Delegates a year ago, because it was assumed by the Reference Committee that it would result in the freezing of too much of the income of the California Medical Association.

There is an amendment to the Constitution which will come up for a vote at this meeting. The Council was instructed by its 1942 House of Delegates to appropriate money for Benevolence if it was needed. No money has been voted for 1943, but an allocation of $5,000.00 in the 1944 budget has been ordered by the Council.

On March 5, 1943, the following reports on receipts and expenditures was made by Mr. John Hunton, Secretary of this Committee. This Committee is supposed to render an annual report to the House of Delegates.

On May 6, 1942, following the close of the 1942 Annual Session, there was a balance of $2,685.65 in the checking account of the Physicians' Benevolence Fund. There was also an additional balance of $4,345.08 in the Savings Account, which was transferred to the care of the "Trustees of the California Medical Association." Since that date there has been no increase in the commercial account, but there has been an increase of $24.22 in the Savings Account from accumulated interest.

During the period from May 6, 1942, to date, there had been 18 payments made from the checking account to beneficiaries. The payments have taken care of the necessary living expenses for some of these men, provided a blood transfusion for one retired physician, paid hospital bills and filled in the financial gaps in other cases. The total payments, since May 6, 1942, amount to $613.15, leaving a balance in the checking account at this time of $2,071.50.

Since that time some contributions from the Woman's Auxiliary have been received and acknowledged by Mr. Hunton.

The Los Angeles County Physicians' Benevolence Association has continued caring for a large number of the needy, and has had very little help from our State Fund.

I have a letter from Dr. Hohl which shows very well what can be done, and is an appeal for more help from our Fund.

(COPY)

"Dear Doctor:

For your information and for an analysis of the Los Angeles Physicians' Aid, our expenditures must be interesting, and, besides all this, we have apportioned among ourselves many hundreds of dollars' worth of medical care to our clients.

"We have had donations of worn suits, overcoats, hats, dresses, shoes, etc., etc., that required soliciting, collecting, cleaning and distribution. We have had huge expenditures for groceries, dental care, drugs, etc., etc., the actual figures for our general expenditures are difficult to arrive at."

Then Dr. Hohl lists a number of these items, totalling $2,571.68.

"This year, with various chairmen and officers overworked, we have had to have an Executive Secretary and have had to pay her $50.00 per month, where previously for distributing and for advising our doctors, she received but $10.00.

"We have four in the hospitals and rest homes now.

"Food costs have increased and naturally we worry a little over our budget. I am wondering just where the State Fund can help us more. It is designated to help out with extras or to supplement the client's own funds. In many instances, as the client gets older and sicker, his own funds are totally inadequate. Mr. Hunton can tell you how much he has sent to us. We could be much more generous than we are, although as it is we get the comforts and necessities which appear small in every case."

(Signed) ELIZABETH M. HOHL.

Dr. Hohl states that the income of the Los Angeles Association is about $1,500.00 a year and is collected

from donations from our Los Angeles members. She states that their expenditures are nearly $350.00 a month to supplement public charity for our people, and that they need at least $200.00 a month from our Fund.

In trying to look ahead and providing for future contingencies, your Committee can see the possibility of increasing the demand for temporary help from our members returning from military duties. Financial assistance during this period of the reëstablishing of a private practice may not be provided by the National Government. Widows and children of some of these members may require help unless generous pensions are promptly paid during these times of high cost of living.

Changed economic conditions, resulting from the war, may render business interest and investments on which some retired members depend nonproductive and valueless. They may need help. The possibility of a somewhat higher Old Age Pension by the State is more than offset by the increasing costs of everything needed to keep alive.

Considering these probable increased demands on our Fund in the near future, in addition to present demands—including $3,600.00 required from the Los Angeles area—your Committee recommends efforts to increase the available funds. Secretaries of county medical societies have been furnished blanks for voluntary contributions, and it is desired that these be mailed to all active members. The Woman's Auxiliary should be encouraged in every way to continue their very valuable activities to raise money for this Fund.

Some broad questions of policy need an answer from the House of Delegates or the Council as to how long should temporary aid be given. We have no money for pensions, but have extended payments and cash for several months until Old Age pensions or county charity could be secured. Are we to continue permanently the present activities of supplementing public charity, or shall we plan and make an effort to accumulate a fund big enough to enable us to pay a pension? We can pay no money to the needy because thereby they forfeit their pension or county allowance. We are merely giving them some food, clothing, drugs and other necessities, and before we do that they must become paupers and ask for public charity.

It seems possible and probable that about the best thing and what we can do most is to give the public a big boost if we plan to provide a decent living allowance for our poor and unfortunate by a yearly allocation of $5,000.00 a year with other possible sources of income. Under normal times and conditions that would soon build up a surplus, while we continue our policy of simply supplementing public charity.

A Social Security fund, patterned after the Federal Government system, has been thought of as a possible solution of the problem of providing against indigency. A yearly payment by every member to such a fund would constitute insurance against misfortune. If a member never required help he would have the satisfaction of knowing he helped someone who did.

Thank you. (Applause.)

SPEAKER GOIN: The report of Dr. Anderson's Committee will be referred to Reference Committee Number 1.

* * *

For the purpose of receiving an addendum to the Report of the Council, I will call on Capt. Philip K. Gilman, Chairman of the Council.

CAPT. PHILIP K. GILMAN (San Francisco): The following resolution is added to the Report of the Council.

Reference Number 2: (See 25 and 35.)

Resolution Regarding Industrial Fee Schedule

Resolved, That the House of Delegates of the California Medical Association hereby reiterates its disapproval of the present inadequate fee schedule of the California Industrial Accident Commission, adopted nearly twenty-three years ago, and respectfully requests the Industrial Accident Commission to adopt the revised fee schedule submitted by the California Medical Association to the Commission on October 16, 1942; and be it further

Resolved, That the California Medical Association hereby expresses its unqualified disapproval of any practices under Workmen's Compensation laws involving the rebate of fees in any form or manner, the payment of physicians on the basis of a percentage of premiums collected, or otherwise, at a rate less than the fee schedule established by the Industrial Accident Commission; and be it further

Resolved, That a special committee of three, to be appointed by the Chairman of the Council, is hereby created to represent the California Medical Association in all matters relating to Workmen's Compensation practice, and to carry into effect the policies hereinabove set forth.

SPEAKER GOIN: The Report of the Council, together with the addendum, will be referred to Reference Committee Number 2.

* * *

We now come to Item 14 of the Agenda—*Unfinished Business*. Under this heading appears *"Proposed Amendments to Constitution."* There is an amendment pending, concerning *"Annual Allocation of One Dollar to C.M.A. Physicians' Benevolence Fund"* and it has been published. Without any discussion, this amendment which appeared in the OFFICIAL JOURNAL of April, 1943, on page 164, is referred to Reference Committee Number 3.

* * *

In introducing your *Resolutions*, please have your *resolutions in triplicate* and present them to the Secretary. In presenting a resolution to the House, please give your name and county association. As the reporter does not know you, please give your name, neither do I know all of you.

The Chair will recognize Capt. Philip Gilman who will present a resolution.

CAPTAIN PHILIP K. GILMAN: The following resolution is submitted.

Reference Number 3: (See 40.)

Proposed "Military Colleagues' Postgraduate Fund"

WHEREAS, Large numbers of members of the California Medical Association have given up civilian practice to enroll as medical officers in the Medical Corps of the United States Army and Navy, and in so doing, when they return to practice in civil life, may find themselves temporarily handicapped by the sharp change from military to civilian medicine; and

WHEREAS, Members of the California Medical Association who, for various reasons, are obliged to remain in civilian practice wish to give expression of their appreciation and regard for the sacrifices and services rendered by their fellow members who have enrolled with the Armed Forces of our Country; therefore be it

Resolved, By the House of Delegates of the California Medical Association that a proposed amendment to the Association's By-Laws, through which a separate fund would be established to make possible the granting of honoraria to cover the costs of postgraduate or refresher courses of at least six weeks' duration, for colleagues returning from military service, be approved in principle; and be it further

Resolved, That it is suggested that the said fund shall be established in the year 1943, and that the Council of the Association be requested to set aside and earmark in a fund, to be known as the Military Colleagues' Postgraduate Fund, the sum of two dollars from the annual dues of each member of the Association whose State Association dues have been received from the county medical society in which he is an active member; and be it further

Resolved, That if the fund be established, it is suggested that the expenditures from this fund be placed under the jurisdiction of a special committee to be known as the Committee on Postgraduate Courses for Military Colleagues; the said committee to consist of five members appointed by the Council (three from the general mem-

bership and two ex-officio members, one the chairman and the other the secretary of the standing Committee on Postgraduate Activities); provided, however, that if brought into being, the said Special Committee's general policies and expenditures must be submitted to and have the approval of the Council of the Association; and be it further

Resolved, That it be suggested the fund so established be continued and added to each year, in similar manner, through appropriation by the Council, except as the House of Delegates in any year may give other instructions to the Council; it being provided that the Association's House of Delegates may in its discretion at any time terminate the work of the Special Committee, and make provision for the transfer of moneys remaining in the Military Colleagues' Postgraduate Fund to such other fund or funds of the Association as may be deemed desirable.

SPEAKER GOIN: The resolution is referred to Reference Committee Number 3.

CAPTAIN GILMAN: The following is a *Proposed Amendment* to the California Medical Association By-Laws to enable that to be done which I have just indicated.

Reference Number 4:

Proposed (a) Committee on Postgraduate Courses for Military Colleagues'; and (b) Military Colleagues Postgraduate Fund

Resolved, That a new section be added to Chapter V of the California Medical Association By-Laws through an amendment as follows:

Chapter V. Committees.

Section 24(a) Committee on Postgraduate Courses for Military Colleagues.

(b) Military Colleagues' Postgraduate Fund.

(a) Committee on Postgraduate Courses for Military Colleagues:

A committee, to be known as the Committee on Postgraduate Courses for Military Colleagues, shall be appointed by the Council within 90 days after the adjournment of the Annual Session at which this amendment is adopted by the House of Delegates.

The Committee shall consist of five members to be appointed by the Council. Three of these shall be selected from the active members of the Association, their terms of office being for three years; provided, that in the first committee appointed, one member shall be given a term of one year, another, two years, and the third, three years. The Council shall designate one of the three members so appointed as chairman. In addition, there shall be two ex-officio members, one being the chairman of the Committee on Postgraduate Activities and the other its secretary. The ex-officio members shall not have the right to vote in the Committee.

(b) Military Colleagues' Postgraduate Fund:

A fund to be known as the "Military Colleagues' Postgraduate Fund" shall be established by the Council, beginning with the current year, 1943, as follows:

The Council in the year 1943 and in each year thereafter, until otherwise instructed by the House of Delegates, shall allocate from the dues of every active member as received from a component county medical society, the sum of two dollars ($2.00) and shall place the same in a separate fund under the above name. Expenditures from the said fund shall be limited to the expenses involved in furnishing postgraduate or refresher courses to military members of the Association, returning from military to civilian practice; provided, that the Committee on Postgraduate Courses for Military Colleagues shall first receive the approval of the Council concerning its general policies in regard to postgraduate or refresher courses, and that its general financial policies shall likewise first receive the approval of the Council.

The Committee on Postgraduate Courses, prior to beginning its active work, shall formulate and submit to the Council for approval a detailed report in which its recommendations and proposed procedures will be outlined. Such a report shall be submitted by the Committee at each Annual Session. Special reports shall be submitted at other times on either the Committee's initiative or in response to request from the Council.

SPEAKER GOIN: This being a By-Law Amendment, it may be acted upon at the second session of this House tomorrow. It is referred to Reference Committee Number 3.

We will continue under Resolutions and New Business. The Chair recognizes Dr. Kress:

SECRETARY KRESS: Mr. Speaker: The following is a proposed Amendment to the Constitution:

Reference Number 5:

Proposed By-Law Amendment Concerning Retired Members

Amend Article IV, Section 1(c) of the Constitution of the California Medical Association:

The Section 1(c) of Article IV of the Constitution of the California Medical Association is hereby amended by adding, immediately after the first paragraph contained in said section 1(c) a full new paragraph:

If an application for retired membership is submitted by a component medical society within the calendar year immediately succeeding the last calendar year in which the recommended applicant was an active member in good standing, the Council shall have authority to act on such application as though it had been submitted in the preceding calendar year during which active membership existed.

So that the said Section 1(c) of Article IV will therefore read:

(c) Retired Members:

Qualifications.—Retired members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who cease the practice of medicine for reasons satisfactory to such component county society and the Council, and who shall have been active members of the Association for ten years or more prior thereto.

Then follows the portion before read, the provision being made, Mr. Speaker, to make it possible for the Council to act upon these applications. Many of these applications are submitted in January and February of a succeeding year. Under the present By-Law, applications can be considered only when the applicant has active membership. In any calendar year, if dues are not paid on or before April 1st, active membership then ceases as of date of April 1st.

SPEAKER GOIN: This Amendment to the Constitution will remain on the table of the House for one year. It will be published twice and will come to the attention of the House for action at the next Annual Session.

The introduction of *Resolutions or New Business* is now in order.

DR. ELIZABETH MASON-HOHL (Los Angeles): Mr. Speaker, I submit the following resolution:

Reference Number 6: (See 1, 39 and 41.)

Proposal That Council Shall Outline Certain Procedure Policies of the Physicians' Benevolence Committee

WHEREAS, Physicians who are recipients of old-age or other financial assistance in California receive only $18.00 to $23.00 a month from county sources or $40.00 to $45.00 a month from State sources; and

WHEREAS, These sums are insufficient to provide decent minimum living standards for these aged and needy persons; and

WHEREAS, Additional physicians may require financial assistance after they return from military service to which they are devoting their time and their lives, and for which they may not be adequately compensated for the maintenance of personal, family and professional obligations; therefore be it

Resolved, That the House of Delegates instruct the Council to determine the policy of the Physicians' Benevolence Committee in the (1) matter of dispensing aid to the needy, (2) defining temporary aid and determining the limitations and amount of such payments, and (3) the policy in regard to the raising of funds with particular reference to the question of whether the committee should limit the raising of funds to approximately $5,000.00

a year to be paid out in supplemental charity aid, and temporary relief, or (4) should strive to raise a much larger sum, by bequests, donations, voluntary contributions, and appropriation of California Medical Association funds for the establishment of an endowment fund which would eventually supply an income for current benevolence from year to year, and (5) ultimately develop a system of regular pension payments to take our needy out of the pauper or public charity class.

SPEAKER GOIN: This resolution will be referred to Reference Committee Number 3.

DR. LOUIS J. REGAN (Los Angeles): The following resolution is submitted:

Reference Number 7: (See 42.)

Proposal Concerning Special Committee on Post-War Plans for Medical Care

WHEREAS, There has been and is great public interest in problems of Social Security; and

WHEREAS, A number of "plans" have been put forward to meet the health needs of the community, and of the low-income groups particularly; and

WHEREAS, It appears that consideration is being given to these various "plans" by representatives of other schools of the healing profession, frequently in association and consultation with sociologists and economists; and

WHEREAS, In respect to a matter of such vital importance to physicians, and to the welfare of the community, that there may be no semblance of lack of interest, initiative, or understanding; therefore be it

Resolved, That the Council of the California Medical Association be instructed to appoint a Special Committee on post-war plans for medical care to study the problems of Social Security insofar as the health, and medical and hospital care of the people of this State are concerned, to study the more important plans and formulae already suggested, together with their implications, as they affect or may affect the physician-patient relationship, and to report to the Council its conclusions and recommendations.

SPEAKER GOIN: This resolution will be referred to Reference Committee Number 3.

Reference Number 8: (See 43.)

Proposal to Instruct C.M.A. Delegates to A.M.A. to Introduce a Resolution Concerning an A.M.A. Committee on Medical Service

DR. E. W. HAYES (Los Angeles County): Mr. Speaker: I wish at this time to present to this body a resolution which was first presented to and adopted by a group representing the North Central States meeting as part of the National Conference on Medical Service. This was in November, 1942, at St. Paul, Minnesota.

Again, on February 14, 1943, physician-representatives of 29 of the middle states met and adopted this resolution, and it is at their request that this resolution is being presented here at this time with the hope that California and other western states will see fit to act favorably upon this resolution.

This resolution is to be presented to the House of Delegates when we meet in Chicago in June.

It is as follows:

(Note. Due to lack of space and because the resolutions submitted by Dr. Hayes appeared in the May issue of CALIFORNIA AND WESTERN MEDICINE, on pages 292-294, they are not here reprinted.)

DR. L. A. ALESEN (Los Angeles): I wonder if the House is clear about the resolution just introduced by Dr. Hayes. It seems perfectly apparent to me it is not the intent of the backers of this resolution to have it adopted by this House of Delegates, but their intent is that this House should instruct the delegation from California to attempt to secure its adoption in the House of Delegates of the American Medical Association. If I am correct in that assumption, the resolution should be accompanied by a resolution something to this effect:

Resolved, That the delegation from California to the American Medical Association convention be, and they are hereby instructed to introduce and attempt to secure the adoption by the House of Delegates of the American Medical Association of the within resolution.

Am I correct in that, Dr. Hayes?

SPEAKER GOIN: The matter is not one for adoption by this House. You want the delegates from California to introduce this resolution to the American Medical Association so you will introduce the resolution as it has just been worded?

DR. HAYES: Yes.

SPEAKER GOIN: This resolution will be referred to Reference Committee Number 3.

DR. ALESEN: I wish to present the following resolution:

Reference Number 9: (See 26 and 44.)

Proposal to Establish a Section on Public Health

WHEREAS, None of the twelve scientific sections of the California Medical Association emphasizes the importance of Preventive Medicine and Public Health; therefore be it

Resolved, By the House of Delegates that a new section to be known as the Section on Public Health be herewith established.

SPEAKER GOIN: This resolution will be referred to Reference Committee Number 3.

DR. DELL T. LUNDQUIST (Santa Clara County): I wish to submit the following resolution, briefly worded, but which seems to me important.

Reference Number 10: (See 45.)

Proposal Concerning Medical Ethics in Relation to War and Post-War Problems

Resolved, That the Council of the California Medical Association be requested to bring before the House of Delegates of the California Medical Association, at its next Annual Session, an extension of the principles of medical ethics of the American Medical Association, to deal with war and post-war problems, and to correlate the various county societies.

SPEAKER GOIN: The resolution is referred to Reference Committee Number 3.

DR. R. STANLEY KNEESHAW (Santa Clara County): This is a proposed resolution relating to the procurement of an adequate supply of medical officers for the Armed Forces of the United States.

Reference Number 11: (See 46.)

Proposal Concerning Procurement of Adequate Supply of Medical Officers for the Armed Forces

WHEREAS, In carrying through the plans of our Country's War Manpower Commission, the Surgeon Generals of the United States Army and Navy, through their respective Procurement and Assignment Services and allied bodies, have called upon the medical profession of the United States to provide an adequate supply of medical officer personnel, to the end that the ten million and more soldiers and sailors in the Armed Forces may be assured of medical care that will make for the fullest possible conservation of health and life; and

WHEREAS, California is one of the limited number of States in the Union that has thus far materially fallen behind in supplying its proportion and quota of medical officers; and

WHEREAS, The medical profession of California must not be found wanting in its patriotic obligations, with lasting stigma in case it fails to respond and meet its share of our Country's obligations; and

WHEREAS, It was found in World War I, that the decision—on whom among practicing physicians, according to age and other requirements and responsibility—was a matter that could be decided in greatest fairness through the opinions and judgments of local county committees of physicians, who would declare what physicians in their respective districts were seemingly the most available for military service; be it

Resolved, That the House of Delegates of the California Medical Association call upon the component county medical societies to bring into existence in their respective counties, committees of three to five members, the function of which will be the determination concerning availability of physicians in their counties; and be it further

Resolved, That the county committees so constituted be urged to use all legitimate ways and means to induce available physicians to promptly file their applications for service with the United States Army or Navy; and be it further

Resolved, That the county society committees so constituted work with and through the California Committee on Procurement and Assignment Service, of which Harold A. Fletcher, M. D., of San Francisco is Chairman, and Edward M. Pallette, M. D., of Los Angeles, is Vice-Chairman, the latter in relation to the fourteen southern counties and the former with supervision of the remaining counties of the State.

SPEAKER GOIN: The resolution will be referred to Reference Committee Number 3.

* * *

The Chair recognizes the Secretary, Dr. Kress, to introduce a resolution on behalf of the Council.

Reference Number 12: (See 36.)

SECRETARY KRESS:

Proposal Regarding Councilor Districts

Resolved, That the House of Delegates in accordance with the By-Law provisions, reaffirm or modify the existing arrangements of Councilor districts.

SPEAKER GOIN: The resolution is referred to Reference Committee Number 2.

* * *

DR. JESSE L. CARR (San Francisco): The following resolution is submitted:

Reference Number 13: (See 47.)

Proposal to Instruct C.M.A. Delegates to A.M.A. Regarding a Procurement and Assignment Service for Nursing Personnel for the Armed Forces

WHEREAS, There exists no routine and proper means of procuring nurses for the Armed Forces; and

WHEREAS, The only provision of nurses for the Armed Forces has been by enlistment through pressure groups and recruiting squads; and

WHEREAS, The proper delegation and assignment of nurses is as important to the military and civil population as is the delegation and assignment of physicians; therefore be it

Resolved, That the delegates from the California Medical Association to the American Medical Association be instructed to instigate and/or support a movement to establish a procurement and assignment service for nursing personnel for the military forces of the United States.

SPEAKER GOIN: This resolution is referred to Reference Committee Number 3.

* * *

DR. JOHN C. SHARP (Monterey County): Mr. Speaker, and Members of the House of Delegates: This resolution emanates from the Monterey County Medical Society and was originally sent to the Council of the California Medical Association in February of this year. We are now presenting it before the House of Delegates.

Reference Number 14: (See 48.)

Proposal that C.M.A. Council Institute a Survey Concerning Problems Related to Nursing Personnel

WHEREAS, It has come to the attention of the Monterey County Medical Society that there have been problems in connection with working out an adequate nursing supply for both the Armed Forces and civilian population, and that these problems have not only concerned themselves with the shortage of nurses but also with the question of salaries, wages and working conditions of nurses; and

WHEREAS, It has come to our attention that, at the present time, a ballot is being taken among the members of the State Nurses Association requesting a vote as to a 15 per cent increase in salaries over the 1941 pay schedule adopted by the State Nurses Association in that year and further authorizing the Board of Directors of the State Nurses Association to act as a collective bargaining agency for salaries, wages and working conditions among the nurses of California; and

WHEREAS, In connection with the above ballot a pamphlet has been printed and circulated by the California State Nurses Association, entitled, "C.S.N.A. and the Economic Security of its Members," in which certain statements are made in regard to the attitude of the hospitals in regard to the above problems which have not been solved, and other statements have been made relative to collective bargaining in regard to salaries and wages; therefore be it

Resolved, That the Monterey County Medical Society in regular meeting assembled does hereby request the Council of the California Medical Association to initiate steps in investigation of the problems relating to the shortage of nurses, and the problems discussed in the above named pamphlet, and take whatever steps are deemed necessary by the Council of the California Medical Association to bring a harmonious and fair solution of such problems.

SPEAKER GOIN: This resolution is referred to Reference Committee Number 3.

* * *

Executive Session

DR. BRYANT R. SIMPSON (San Diego): We have a resolution to present. I move that we go into Executive Session.

DR. W. H. GEISTWEIT, JR. (San Diego): I second the motion.

The motion was put to a vote and it was carried.

SPEAKER GOIN: It is so ordered. The Chair will appoint two Sergeants-at-Arms. The duties of the Sergeants-at-Arms will be to clear the House of all but the Executive Officers and those sitting as Delegates. Dr. Leo J. Madsen and Dr. James Doyle will act as Sergeants-at-Arms.

The Sergeants-at-Arms cleared the House of all those except the Executive Officers and members of the House of Delegates.

SPEAKER GOIN: The Chair rules that all delegates present are members of the House of Delegates. Are the Sergeants-at-Arms ready to report?

DR. LEO J. MADSEN: The House is duly constituted for Executive Session.

SPEAKER GOIN: If there is any person present who is not a member of the House of Delegates you would confer a great obligation on the House by retiring. If there is not, the House is in Executive Session and the Chair recognizes Dr. Blondin of San Diego.

DR. BLONDIN (San Diego): The following resolution is submitted:

This resolution is a little bit long, but we think it is important. . . .

Reference Number 15: (See 49.)

Concerning Medical Service Procedures by C.P.S. in San Diego County Federal Housing Projects

(Note. The minutes of the proceedings of the Executive Session of the House of Delegates are on file in the office of the California Medical Association. Delegates who were present are in position to give reports to their respective county societies.

The Council of the Association will hold a two-day session on June 19-20, at which time the various problems involved will be given careful consideration. In due course, the component county societies will receive reports thereon.)

SPEAKER GOIN: The resolution is referred to Reference Committee Number 3.

* * *

Regular Session Resumed

SPEAKER GOIN: Is there any occasion to remain in Executive Session? If not, the Chair will entertain a motion to retire from Executive Session.

DR. SCHAUPP: I so move.

DR. BRUCK: Second the motion.

SPEAKER GOIN: It is so ordered.

Are there any further resolutions to be introduced?

If not, the Chair will remind you that every member of the House of Delegates has not only the right and

privilege, but the actual duty to appear before the Reference Committees that have in charge any resolution in which that member is interested. The places of meeting of the Reference Committees will be posted upon the bulletin board. . . .

I will ask Dr. Ayres to indicate the hour at which Reference Committee Number 3 will meet?

DR. AYRES: It will meet immediately following the adjournment of this session.

DR. GEISTWEIT: Reference Committee Number 2 will meet at 9:30 tomorrow morning.

SPEAKER GOIN: We urge you to attend these meetings and say what you have to say about these resolutions.

Is there any further business to come before the House? If not, I would like to say that the House will convene tomorrow at one o'clock. We really will convene at one o'clock, as we have some work to do. It is going to take a long time, so please be prompt.

If there is no further business, the Chair will entertain a motion to adjourn?

DR. L. A. ALESEN: I move we adjourn.

DR. JAMES C. DOYLE: I second the motion.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is so ordered.

The House will convene tomorrow at one o'clock.

The House stands adjourned.

The House recessed at 3:00 P.M., Sunday, May 2nd, 1943, to reconvene Monday, May 3rd, 1943, at 1:00 P.M.

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Second Meeting, Monday Noon, May 3, 1943, in the Music Room, Hotel Biltmore

The Second Meeting of the House of Delegates of the California Medical Association was held in the Music Room of the Biltmore Hotel, Los Angeles, California, Monday, May 3, 1943. The meeting was called to order at 1:15 P.M. by the Vice-Speaker, Dr. E. Vincent Askey of Los Angeles.

VICE-SPEAKER ASKEY: The House will please come to order. Those of you who have not signed your cards and wish to be seated, please sign your cards at once.

I will call for the Report of the Committee on Credentials to see whether or not we have a quorum present. Dr. Hoffman.

DR. EUGENE HOFFMAN: Mr. Speaker, the Credentials Committee begs to report that more than thirty-five delegates, the minimum number necessary for a quorum, have been registered.

Mr. Secretary, is there a quorum present?

SECRETARY KRESS: A quorum is present.

VICE-SPEAKER ASKEY: There being a quorum of this House present, the meeting is hereby called to order and we are in business session.

We will now proceed to the Roll Call of Delegates, so that each delegation may seat additional members if there is a deficiency in their numbers. The way it will be handled will be that the Secretary will call the Roll at this time, and if there is no answer from the Roll Call at this time an alternate from the county or the chairman from the delegation may seat an alternate. We will proceed in this manner and then, at the finish of the Roll Call, there will be no need to retrace our steps.

Mr. Secretary, will you proceed with the Roll Call and the seating of the delegates.

The Roll was called by Secretary Kress, and the delegates and alternates were seated.

SECRETARY KRESS: Mr. Speaker, the Roll Call is completed.

VICE-SPEAKER ASKEY: The Report of the Secretary and the Roll Call being completed, I hereby declare this House duly constituted and ready for business.

The next order of business will be an announcement by our Secretary in regard to the place for our 1944 Annual Session.

SECRETARY KRESS: Mr. Speaker: The Council has decided to postpone its decision concerning the place of meeting for next year's Annual Session. The session, if and when and where held, will be dependent upon contingencies that may come into being during the coming year.

VICE-SPEAKER ASKEY: You have heard the Report of the Secretary in regard to the action of the Council.

We will now proceed with the next order of business, which is the election of your officers.

Reference Number 16:

Election of Officers

VICE-SPEAKER ASKEY: The first office to be elected is that of the *President-Elect* for the coming year. Are there any nominations for this office?

Election of President-Elect Lowell S. Goin

DR. EDWARD M. PALLETTE (Los Angeles): The California Medical Association House of Delegates has had only a few Speakers, but each time that Speaker has eventually been elected President of the Association. I am going to ask you at this time to continue that custom.

Dr. Lowell S. Goin was born in Iowa. Incidentally, Los Angeles is the Iowa City in America, so that he has plenty of fellow countrymen who speak his language. Dr. Goin prepared for premedical at the University of Iowa and he graduated from the Medical University of St. Louis in 1911. Then, after the usual internship and residence, he followed in the footsteps of Dr. Hertler of the Middlewest, and became a horse-and-buggy country practitioner in Iowa.

Then the World War came on, and Dr. Goin was made a Captain in the Medical Corps, serving 18 months in France, doing x-ray work which he had taken up before the war. After the war, he worked as a resident student at Battle Creek Sanitarium for two years. He served one year doing x-ray work at Frankfort, Germany.

Then he saw the stars of destiny in the Middlewest, and came to God's country where he has for twenty years been doing roentgenology. We are all familiar with Dr. Goin's work in Organized Medicine. He has put in a tremendous lot of time for a number of years most effectively.

We have all attended many meetings but I am sure that we have never attended any meetings where the business was conducted any more efficiently, and more promptly and fairly than it has been conducted in this House of Delegates in recent years.

I take great pleasure in nominating Dr. Lowell S. Goin, of Los Angeles, for the office of President-Elect of the California Medical Association. (Applause.)

VICE-SPEAKER ASKEY: You have heard the nomination. Are there any other nominations for this office?

It was moved, seconded and carried the nominations be closed, and that the Secretary cast the ballot.

VICE-SPEAKER ASKEY: The nominations are closed—how will you vote?

The vote was taken by acclamation and it was unanimously carried that Dr. Lowell S. Goin be elected President-Elect.

VICE-SPEAKER ASKEY: The Chair declares Dr. Goin elected President-Elect of the California Medical Asso-

ciation. At this time I wish to present to you your Speaker of the House—Dr. Lowell S. Goin. (Applause.)

Dr. Goin assumed the chair.

Election of Speaker E. Vincent Askey

SPEAKER GOIN: The next order of business is the election of a Speaker of the House of Delegates. The Chair will now hear nominations.

DR. CARL L. MULFINGER (Los Angeles): Quite some years ago in the foothills of Western Pennsylvania, it was my privilege to be in a small college with the man about to be nominated the Speaker of the House of Delegates. I admired him because he played end at football and weighed about 140 pounds. This small college had to buck up against colleges like Dartmouth and Cornell, Pittsburgh and what have you, but, irrespective of the opposition, he was right there and played the game to the end.

Ever since then he has been playing the game for all it is worth. He is known to most of the men here in this State for his services to Organized Medicine. He is not only known to us here in the Southern end of the State for his services to Organized Medicine, but for his services to his community as an outstanding member and president of the Board of Education of the city of Los Angeles.

It is a pleasure for me to nominate Dr. Vincent E. Askey for Speaker of the House of Delegates. (Applause.)

SPEAKER GOIN: Dr. E. Vincent Askey is nominated. Are there any other nominations for this office?

If there are none, the Chair will declare the nominations closed. Hearing none, they are closed.

By acclamation, a vote was taken and Dr. E. Vincent Askey was unanimously elected.

SPEAKER GOIN: It is carried and so ordered. Dr. E. Vincent Askey is elected to that office. (Applause.)

Election of Vice-Speaker L. A. Alesen

Nominations are now in order for the office of Vice-Speaker of the House of Delegates.

DR. CARL R. HOWSON (Los Angeles): Mr. Speaker and Delegates: For the office of Vice-Speaker of the House of Delegates I would like to place in nomination the name of Dr. L. A. Alesen, the present Secretary of the Los Angeles County Medical Association. Dr. Alesen needs no introduction to this group. For the last several years he has been Secretary of our Association and has proved himself a very outstanding Secretary. He has made a little name for himself as an editorial writer, which is incidental to his ability as a parliamentarian. For 15 years he has represented one of the medical schools in Los Angeles in their Department of Surgery, and, as far as we are concerned, particularly the Los Angeles County delegation, he has never done anything but put up a valiant fight for the good name of Medicine.

I consider it a pleasure to nominate Dr. Alesen for Vice-Speaker.

SPEAKER GOIN: Dr. L. A. Alesen has been nominated for Vice-Speaker.

DR. WILCOX: I take pleasure in seconding that nomination.

SPEAKER GOIN: Are there any further nominations? If there are none, the Chair will declare the nominations closed. Hearing none, they are closed. How will you vote?

A vote was taken by acclamation and Dr. Alesen was unanimously elected as Vice-Speaker.

SPEAKER GOIN: Dr. Alesen is declared elected to the office of Vice-Speaker.

Reference Number 17:

Election of District Councilors: Harry E. Henderson, Santa Barbara (for 3rd District); John W. Cline, San Francisco (for 6th District); John W. Green, Vallejo (9th District); and Lloyd E. Kindall, Oakland (7th District)

The next order of business is the election of District Councilors. The first vacancy is in the Third District, Dr. Harry E. Henderson of Santa Barbara, incumbent, term expiring. Mr. Secretary, do you have a nomination in writing?

SECRETARY KRESS: Mr. Speaker, Dr. Harry E. Henderson is the nominee of the Delegates of the Third District.

SPEAKER GOIN: A vote was taken by acclamation and Dr. Harry E. Henderson was unanimously elected Councilor for the Third District.

SPEAKER GOIN: The next vacancy is in the Sixth District, Dr. John W. Cline, incumbent, term expiring. Mr. Secretary, do you have a nomination in writing?

SECRETARY KRESS: Mr. Speaker, Dr. John W. Cline has been nominated by the delegation of the Sixth District.

SPEAKER GOIN: We will now proceed to elect the Councilor from the Sixth District.

A vote was taken by acclamation and Dr. John W. Cline was unanimously elected Councilor for the Sixth District.

SPEAKER GOIN: There is a vacancy in the Ninth District, Dr. John W. Green, Vallejo, incumbent, term expiring. Mr. Secretary, do you have a nomination in writing?

SECRETARY KRESS: Mr. Speaker, Dr. John W. Green has been nominated by the delegation from the Ninth District.

SPEAKER GOIN: Are there any other nominations? Hearing none, I declare the nominations closed.

A vote was taken by acclamation and Dr. John W. Green was unanimously elected Councilor for the Ninth District.

SPEAKER GOIN: There is a vacancy occurring by occasion of the regrettable death of Dr. Frank R. Makinson, Councilor of the Seventh District. Nominations are now in order to fill the unexpired term of Dr. Makinson.

SECRETARY KRESS: Mr. Speaker, Dr. Lloyd Kindall has been nominated to fill the unexpired term of the late Dr. Makinson.

There being no further nominations, a vote was taken on the nomination and it was unanimously carried.

SPEAKER GOIN: I hereby declare Dr. Kindall duly elected to that office.

Reference Number 18:

Election of Councilors-at-Large: Dewey R. Powell, Stockton; and Edward B. Dewey, Pasadena

The next order of business is the election of the Councilors-at-Large, Dr. Dewey R. Powell of Stockton, term expiring. These nominations must come from the floor.

DR. RAYMOND L. OWENS (San Joaquin County): I nominate Dr. Dewey R. Powell to succeed himself.

SPEAKER GOIN: Dr. Powell is nominated to succeed himself. Are there any further nominations? If not, the Chair will declare the nominations closed.

A vote was taken on the nomination and Dr. Powell was unanimously elected.

Speaker Goin: Dr. Powell is elected to succeed himself as Councilor-at-Large.

The next is the election of a Councilor-at-large to fill the vacancy of Dr. Edward B. Dewey of Pasadena, term expiring.

Dr. E. T. Remmen: Mr. Speaker and Members of the House: Three years ago at Coronado there were two candidates for a certain vacancy for Councilor-at-large. I was one and the delegate from Pasadena was the other. After the campaign, when the votes had been counted, the delegate from Pasadena had the largest number of ballots. He has been an able Councilor, studious, thoughtful and faithful. I ask the privilege, Mr. Speaker, of placing in nomination to succeed himself, Dr. Edward B. Dewey of Pasadena.

Speaker Goin: Dr. Edward Dewey is nominated. Are there any further nominations? If there are none, the Chair will declare the nominations closed.

A vote was taken on the nomination and Dr. Dewey was unanimously elected to succeed himself.

Speaker Goin: Dr. Edward B. Dewey of Pasadena is hereby declared elected to succeed himself.

Dr. Askey assumed the Chair.

Reference Number 19:

Election of Delegates to the American Medical Association: Dwight L. Wilbur, San Francisco (1944-1945); Lyell C. Kinney, San Diego (1944-1945); Lowell S. Goin, Los Angeles (1944-1945); Henry S. Rogers, Petaluma (1944-1945); Lowell S. Goin, Los Angeles (1943); William H. Kiger, Los Angeles (1943-1944)

Vice-Speaker Askey: The next item of business is the election of Delegates to the American Medical Association convention from the California Medical Association.

The first will be that of Dwight L. Wilbur of San Francisco, term expiring. Are there any nominations for this office?

Dr. Charles A. Noble, Jr. (San Francisco): I would like to place in nomination the name of Dr. Dwight L. Wilbur to succeed himself.

Vice-Speaker Askey: You have heard the nomination. Are there any other nominations? Hearing none, the Chair will declare the nominations closed. Dr. Dwight L. Wilbur is nominated as a Delegate from this Association to the American Medical Association.

A vote was taken on the nomination and Dr. Dwight L. Wilbur was elected.

Vice-Speaker Askey: Dr. Wilbur is declared elected.

(Note. In similar manner, other delegates whose names appear above, were nominated and elected for service for the calendar years indicated.)

Reference Number 20:

Election of Alternate Delegates to the American Medical Association: L. R. Chandler, San Francisco (To Delegate Wilbur, 1944-1945); Bon O. Adams, Riverside (To Delegate Kinney, 1944-1945); Leo J. Madsen, Santa Monica (To Delegate Goin, 1944-1945); Robert S. Stone, San Francisco (To Delegate Rogers, 1944-1945); Robert T. Legge, Berkeley (To Delegate Ewer, 1943-1944); Donald G. Tollefson, Los Angeles (To Delegate Kiger, 1943-1944)

Vice-Speaker Askey: The next will be the election of the Alternates to the American Medical Association. The first is that of Dr. L. R. Chandler of San Francisco who is Alternate to Dr. Dwight L. Wilbur.

Dr. Noble (San Francisco): I want to place in nomination the name of Dr. L. R. Chandler to succeed himself as Alternate.

Vice-Speaker Askey: You have heard the nomination of Dr. Chandler to succeed himself. Are there any further nominations? If not, the Chair declares the nominations closed.

A vote was taken on the nomination of Dr. Chandler and it was unanimously carried.

Vice-Speaker Askey: Dr. Chandler is declared elected.

(Note. In similar procedure, the other alternates were elected by acclamation.)

Reference Number 21:

Announcement and Approval of Members of Standing Committees Elected by the Council

We will now have by the Secretary the Announcement and Approval of Members of Standing Committees elected by the Council. Mr. Secretary.

Secretary Kress: The Council's Committee on Committees (Doctors Green, Rogers and Emmons) has made the following recommendations for existing vacancies (the same being for three year terms on standing committees):

Committee on Associated Societies and Technical Groups,
Dr. John V. Barrow (Chairman).

Committee on Health and Public Instruction,
Dr. J. C. Geiger, San Francisco.

Committee on History and Obituaries,
Dr. Hyman Miller, Los Angeles.

Committee on Hospitals, Dispensaries and Clinics,
Dr. Benjamin W. Black, Oakland.

Committee on Industrial Practice,
Dr. Carl L. Hoag, San Francisco.

Committee on Medical Defense,
Dr. Lewis T. Bullock, Los Angeles.

Committee on Medical Economics,
Dr. Edward C. Pallette, Los Angeles.

Committee on Medical Education, and Medical Institutions,
Dr. William J. Kerr, San Francisco.

Committee on Membership and Organization,
Dr. L. H. Redelings, San Diego.

Committee on Postgraduate Activities,
Dr. Frank Clough (Chairman), San Bernardino.

Committee on Publications,
Dr. George W. Walker (Chairman), Fresno.

Committee on Public Policy and Legislation,
Dr. Edmund T. Remmen, Glendale.

Advisory Committee to Above,
Dr. Junius B. Harris (Chairman), Sacramento,
Dr. H. R. Madeley (Vice-Chairman), Vallejo.

Committee on Scientific Work,
Dr. Fletcher B. Taylor, Oakland.

Editorial Board.

In addition, there have been some changes on the Editorial Board. Dr. Albert J. Scholl of Los Angeles, has been made Chairman of the Executive Committee of the Editorial Board.

During the coming year, Dr. Ernest H. Warnock takes a place on Anesthesiology; Dr. Fred B. Clarke in General Medicine and Dr. Garnett Cheney in General Medicine; Dr. William P. Kroger in General Surgery; William C. Deamer in Pediatrics; Dr. Alvin J. Cox in Pathology, and Dr. Maurice L. Tainter in Pharmacology.

VICE-SPEAKER ASKEY: You have heard the report of the Council Committee as read by the Secretary. For your information, these Committeemen are nominated and elected by the Council subject to approval by this House. You may either move that the report be approved in its entirety or you may take it individually. Which is your wish at this time?

DR. MADSEN: I move it be approved as a whole.

DR. BRUCK: I second the motion.

VICE-SPEAKER ASKEY: Is there any discussion on this motion?

There being no discussion on the motion, it was put to a vote and unanimously carried.

VICE-SPEAKER ASKEY: The nominations by the Council are hereby approved.

* * *

VICE-SPEAKER ASKEY: Mr. Speaker, I will return the chair to you.

Speaker Goin assumed the chair.

* * *

Reference Number 22:

Report of the Committee on Awards in Scientific Exhibit Division

SPEAKER GOIN: The secret committee appointed to pass on Scientific Exhibits has made the following awards:

No. 1—Division of Military Exhibits, first prize consisting of $50.00 and an engraved and framed certificate; to the United States Navy.

Honorable Mention. Office of Naval Officer Procurement for Southern California.

Honorable Mention. Office of Naval Officer Procurement for Northern California.

No. 2—$50.00 and an engraved and framed certificate to the Emergency Medical Division of the State Council of Defense.

No. 3—Health Problems in Wartime—first prize of $50.00 and an engraved and framed certificate for the exhibit on nutrition problems, presented by the University of California.

* * *

REPORTS OF REFERENCE COMMITTEES

SPEAKER GOIN: The next order of business is the presentation of the Reports of the Reference Committees.

Reference Number 23:

REPORT OF COMMITTEE NO. 1: ON "REPORTS OF OFFICERS AND STANDING COMMITTEES"

(J. Frank Doughty, Tracy, Chairman; H. D. Neufeld, Contra Costa; Deon A. Crew, San Luis Obispo.)

SPEAKER GOIN: Number 1 is the Committee No. 1, with report on "Reports of Officers and Standing Committees." Dr. J. Frank Doughty of San Joaquin County is Chairman. Dr. Doughty.

REPORT OF REFERENCE COMMITTEE No. 1

Dr. J. Frank Doughty, Chairman

Mr. Speaker and Members of the House of Delegates: We are trying to streamline our report today:

Report of the President:

President William R. Molony, Sr., like every good leader in wartime, has been at the head of his organization, facing with courage and intelligence the many complex and serious problems of the medical profession and the general welfare. His report is recorded in full in the "Pre-Convention Bulletin," but his deeds far exceed his modest report.

I move the adoption of this section of the report.

DR. BRUCK: I second the motion.

The motion was put to a vote and unanimously carried.

SPEAKER GOIN: It is so ordered.

DR. DOUGHTY:

Reports of the Officers of the California Medical Association:

The Reports of the Officers of the California Medical Association show that each has faithfully discharged his obligations, and has given of his time and effort to the furtherance of the cause of Organized Medicine.

I move the adoption of the reports of the following officers as recorded in the "Pre-Convention Bulletin":

Report of the President-Elect,
Report of the Past-President,
Report of the Speaker of the House of Delegates,
Report of the Vice-Speaker,
Report of the Chairman of the Council.

DR. DOYLE: I second the motion. . . .

(Note. The usual motions were made to accept the sections as read. In what follows, the formula of such proceedings will not be repeated in this printed report.)

Report of the Executive Secretary:

Revenues during the fiscal year were $1,483.00 above the year's budget. This increase, with a gain of $14,010.00 in unexpended budget items, plus a budgeted surplus of $33,012.00, made it possible for the Association to expend $57,405.00 on the Basic Science Act, with the minimum drain on accumulated surplus funds. CALIFORNIA AND WESTERN MEDICINE was produced for $4,688.00 less than the expenditure for 1941. The increased membership dues for 1943, together with other budgetary plans, will probably offset the loss of dues from members in the military service, and increase costs of operation. The loss on the publication of the JOURNAL in 1942 was $574.00 as compared with the loss of $4,535.00 for 1941. Revenue from technical exhibits in 1942 were sufficient to cover the entire cost of the Annual Session, and leave a surplus of $1,384.00. Active service has been rendered to the Procurement and Assignment Committee. An effort has been made to maintain a cordial relationship with the newspaper publishers, but there has been no definite plan of public relations by the Association.

I move the adoption of this section of the report. . . .

DR. CASS: Second the motion.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is so ordered.

Reference Number 24: (See 32.)

Recommendation of a Public Relations Plan:

DR. DOUGHTY: It seems to Reference Committee No. 1 that this Association should have a well-defined plan of public relations with definite objectives, and with established technique. It recommends that the Council of the Association give serious consideration to such a program, and that the carrying out of this program be assigned as one of the duties of the Executive Secretary. We suggest that one of the weaknesses in our present organization is the absence of executive secretaries in most of

our County Medical Societies; and the fact that the President and Secretary in most of the County Medical Societies are not trained in the proper technique of organization work or public relations. We respectfully suggest that the Council work out a plan for such training, and that it might become a duty of the Executive Secretary of the California Medical Association.

No action taken.

Reference Number 25: (See 2 and 35.)

Report of Legal Department (Re Industrial Fee Schedule):

The Report of the Legal Department is concerned chiefly with the effort being made to procure a modernized and adequate fee schedule. We wish, therefore, to present the following resolution:

WHEREAS, The fee schedule approved by the Industrial Accident Commission became effective June 1, 1920, nearly twenty-three (23) years ago; and

WHEREAS, The fees were minimum at that date, but are now totally inadequate; and

WHEREAS, Part of the inadequacy is due to the lack of a fee schedule which covers certain specific procedures; therefore be it

Resolved:

First:—That the Legal Counsel and the Committee on Industrial Practice be empowered to proceed with all measures necessary to procure the adoption of the increase in industrial accident fees as outlined by the Committee.

Second:—That the complete list of the 547 procedures and operations, as drawn up by the Committee, together with the fees therefor as allowed at the present inadequate rate, be sent to every member of the California Medical Association. This will partly offset the loss now sustained by the medical profession due to their lack of understanding of the specific procedures which can be charged for under the present fee schedule.

Third:—That the Legal Department outline the procedure necessary for the proper presentation of a claim to the Industrial Accident Commission for services rendered, the fee for which has been contested.

I move the adoption of this section of the report.

DR. MADSEN: I second the motion.

SPEAKER GOIN: It has been moved and seconded that the House adopt this section of the report, making the resolution proposed the action of the House of Delegates. Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is so ordered.

Reports of the Standing Committees of the C.M.A.:

DR: DOUGHTY:

The formal reports of the Standing Committees are given in full in the "Pre-Convention Bulletin." It appears that these are largely routine, and that the duties of many of the Standing Committees, with few exceptions at the present time, are very minor. Many of these committees held no meetings during the year. It is realized that the written reports of the committees which did have duties to perform, do not represent a full recitation of the work that they did.

I move the adoption of the reports of the following Standing Committees, as printed in the "Pre-Convention Bulletin":

The Executive Committee,
The Auditing Committee,
Committee on Public Policy and Legislation,
Committee on Associated Societies and Technical Groups,
Committee on Health and Public Instruction,
Committee on History and Obituaries,
Committee on Industrial Practice,
Committee on Medical Economics,
Committee on Medical Education and Medical Institutions,
Committee on Medical Defense,
Committee on Publications,
Committee on Postgraduate Activities,
Committee on Membership and Organization,
Committee on Public Relations,
Committee on Physicians' Benevolence,
Cancer Commission.

I move the adoption of this section of the report. . . .

Reference Number 26: (See 9 and 44.)

Committee on Scientific Work:

This committee has done an excellent job of concentrating a good program into a short period of time for this session. Its recommendation for changing the scope and the name of the *"Section on Industrial Medicine and Surgery"* to the *"Section on Preventive and Industrial Medicine and Public Health"* has our endorsement.

I move the adoption of this section of the report.

DR. WEBER: Second the motion.

SPEAKER GOIN: Dr. Doughty, will you read that last sentence again. It seems to conflict with the pending amendment.

DR. DOUGHTY: It is the recommendation of the Committee on Scientific Work to change the scope and the name of the section on "Industrial Medicine and Surgery" to the section on "Preventive and Industrial Medicine and Public Health."

We have not presented any resolution or motion. It is just a motion to accept the report of the Committee on Scientific Work.

DR. KRESS: Mr. Speaker, the original recommendation is as Dr. Doughty has outlined. However, an amendment has been proposed to the By-Laws which would create a new section, with the name "Section on Public Health." The proposed amendment was submitted by the members in the Industrial Section because they preferred to have their Public Health colleagues carry on their work more as a separate section. It might be desirable if the Committee would delay their report on this point provided the Chairman on the Committee on Scientific Work is willing to withdraw the recommendation previously made in order to be in harmony with the desires of the Section on Industrial Medicine and Surgery.

SPEAKER GOIN: Do you move to amend the report? . . .

DR. CASS: The resolution that was introduced yesterday was that the By-Laws be changed so that a new section on Public Health would be substituted, so I do not think that this recommendation is really in order.

SPEAKER GOIN: The Chair does not believe there is any conflict between this proposed amendment and the motion to adopt this section of the report.

There being no further discussion, the motion was put to a vote and it was carried.

SPEAKER GOIN: The motion is carried and it is so ordered.

* * *

Reference Number 27:

"Round Table" for General Practitioners:

Reference Committee No. 1 suggests that it might be advisable to develop a feature particularly for the general practitioners in future programs. Such a feature: as a round table discussion of practical points, of methods or procedures found useful by the men in this field, a "Minute Man" type of program. It should prove universally interesting and could be tried out on an experimental basis.

Reference Number 28:

Committee on Public Health Education:

As published in the "Pre-Convention Bulletin," this committee has completed its work, closed its funds, and asks for a discharge from the House of Delegates.

I move the adoption of this section of the report. I, also, move that the Committee be discharged with honor.

SPEAKER GOIN: Dr. Doughty has recommended that this request be complied with.

DR. DOYLE: I second the motion.

SPEAKER GOIN: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: This section of the report is adopted.

* * *

Reference Number 29:

Committee on Hospitals, Dispensaries and Clinics:

The report of this Committee points to the existing problems of the hospitals, and to the work they have done in meeting the extra load.

Reference Committee No. 1 calls attention to the fact that no complete, overall study has been made of the hospital situation which exists in every county of this state. To undertake such a study requires more than the time which can be given by the voluntary effort of busy practitioners of medicine. We, therefore, recommend that the Council direct that such a study be made by paid, full-time, personnel of the Association, so that a united, intelligent and state-wide program, based on facts, may be put into force, with special attention to governmental hospitalization.

I move the adoption of this section of the report.

DR. FITZPATRICK: I second the motion.

SPEAKER GOIN: The adoption of this requires the Council to undertake such a survey.

DR. R. STANLEY KNEESHAW: I feel that such a survey at this time would be inadvisable, in view of the help required to conduct the survey this year.

SPEAKER GOIN: Is there any further discussion? The question is on the adoption of this section of the report.

There being no further discussion, the motion was put to a vote and the motion lost.

SPEAKER GOIN: It appears that this section of the report is deleted from the report.

Committee on Local Arrangements:

This Committee, with L. A. Alesen as Chairman, has done an excellent job of making available the local facilities for this streamlined session. I move that a special resolution of appreciation be adopted.

I move that this section of the report be adopted. . . .

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: Dr. Doughty, I am sure the House joins me in thanking you for a very efficient and intelligent and complete report by Committee No. 1.

* * *

Reference Number 30:

REPORT OF REFERENCE COMMITTEE NO. 2: COMMITTEE ON REPORTS OF THE COUNCIL AND SECRETARY-TREASURER

(W. H. Geistweit, Jr., San Diego, Chairman; James C. Doyle, Beverly Hills, and E. C. Halley, Sanger.)

DR. GEISTWEIT:

MR. SPEAKER AND MEMBERS OF THE HOUSE OF DELEGATES: Your Committee has considered the various reports and resolutions referred to it and makes the following report:

Item 1. Report of the Council:

Your Committee has no comments to make and recommends that the report be accepted as read and ordered filed.

I move the adoption of this section of the report.

DR. BRUCK: Second the motion.

SPEAKER GOIN: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: This section of the report is adopted.

Reference Number 31:

Item 2. Report of the Secretary-Treasurer:

The Committee has considered this report and recommends that the House of Delegates instruct the Secretary-Treasurer to continue the *publication of the complete reports of the Certified Public Accountants.* I so move.

DR. BRUCK: I second the motion.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: That section of the report is adopted.

DR. GEISTWEIT:

Your Committee has studied the report of the Certified Public Accountants and wishes to commend the Secretary-Treasurer especially on the reduction of the administrative expenses, and the reduction of the expenses of the OFFICIAL JOURNAL.

In the study of the Accountant's report, your Committee notes the matter of *Past Due Notes from the California Physicians' Service.* Your Committee recommends that these notes be brought up to date under direction of our Legal Counsel, and that a formal written report on their status be made annually to the Council of the California Medical Association by the Legal Counsel.

I move the adoption of this section of the report.

DR. BRUCK: I second the motion.

SPEAKER GOIN: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is adopted.

DR. GEISTWEIT: Your Committee recommends that the report of the Secretary-Treasurer be accepted and ordered filed. I so move.

DR. DOYLE: Second the motion.

Reference Number 32: (See 24.)

Item No. 3. Report of the Executive Secretary:

I find that there has been a conflict with our Committee and Committee Number 1 inasmuch as the Report of the Executive Secretary was also referred to us. We have a recommendation in regard to that report which I am sure does not conflict with the recommendation of Committee Number 1. I will read it.

Your Committee has also studied this report, and with reference to Item No. 6 thereof, recommends that the House of Delegates instruct the Council to appoint a subcommittee of its own members, to be called the *Public Relations Publicity Committee,* said committee to coöperate with and advise with the Secretary of the Association and the Executive Secretary for the purpose of carrying on a consistent campaign in behalf of the best interests of the medical profession and general public health. I so move.

DR. BRUCK: Second the motion.

SPEAKER GOIN: Is there any discussion?

DR. BRUCK: I would call your attention to the fact that in the report of Committee No. 1 that section was not acted upon by the House.

DR. GEISTWEIT: I stand corrected.

SPEAKER GOIN: Is there any further discussion on the adoption of this section of the report?

There being no further discussion, the motion was put to a vote and carried.

SPEAKER GOIN: That section of the report is adopted.

Reference Number 33:

Item 3(A). Annual Conference of County Society and State Association Officers:

It is recommended that the Council call an *Annual Meeting of the Presidents and Secretaries of the various County Medical Societies*, a major topic for consideration at these meetings to be the subject of public health publicity. It is suggested that *one meeting be held in the North and one in the South.* This is purely a recommendation without a motion from the Committee.

SPEAKER GOIN: Dr. Geistweit, if the report as a whole is adopted, this recommendation is adopted. This would call for an expenditure of money.

DR. GEISTWEIT: I move the adoption of this section of the report.

SPEAKER GOIN: The motion is on the adoption of this section of the report.

DR. BRUCK: I second the motion.

SPEAKER GOIN: Is there any discussion? This recommendation will require the Council to call an annual meeting of the Presidents and Secretaries of the various County Medical Societies.

DR. CASS: Is this in addition to the annual meeting when the Secretaries of all the County Societies meet with the members of the Standing Committees?

DR. GEISTWEIT: This really is a substitute for that. This year that meeting was not held, and your Committee feels that we should have that meeting annually, but split it up, as suggested, because of difficulties of travel at the present time.

DR. MOODY: Would a motion be in order to amend this by making it contingent upon the exigencies of the war emergency and travel?

SPEAKER GOIN: Yes, I believe so.

DR. ANDERSON: I second the motion.

SPEAKER GOIN: *The amendment is that the recommendation of the Committee be subject to the exigencies of war;* that is to say, if it is not practical to have the meeting, the Council is released from its duty of calling the meeting.

Are you ready for the question on the adoption of the amendment?

A vote was taken on the amendment and it carried.

SPEAKER GOIN: The question is now on the adoption of the motion as amended.

A vote was taken on the motion as amended and it was unanimously carried.

SPEAKER GOIN: It is so ordered.

DR. GEISTWEIT: The report of the Executive Secretary has already been adopted by previous motion, so it is unnecessary to make an additional motion.

Reference Number 34:

Item 4. Report of the Editor:

Your Committee has considered the report of the Editor. It recommends that the report be accepted and ordered filed. I so move.

DR. BRUCK: I second the motion.

SPEAKER GOIN: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: This section is adopted.

Reference Number 35: (See 2 and 25.)

Item 5. Industrial Commission Fee Schedule:

Your Committee has also considered the resolution referred to it concerning the present inadequate fee schedule of the California Industrial Accident Commission. It recommends that the House of Delegates adopt that resolution. I might say that is, also, along the line of the recommendation of the previous committee; however, I feel it covers other phases of the subject, and in due order I have here the copy of the resolution as referred to us by the Council, as an addendum to its Report. I will read the resolution.

Resolved, That the House of Delegates of the California Medical Association hereby reiterates its disapproval of the present inadequate fee schedule of the California Industrial Accident Commission, adopted nearly twenty-three years ago, and respectfully requests the Industrial Accident Commission to adopt the revised fee schedule submitted by the California Medical Association to the Commission on October 16, 1942, as amended; and be it further

Resolved, That the California Medical Association hereby expresses its unqualified disapproval of any practices under Workmen's Compensation laws involving the rebating of fees in any form or manner, the payment of physicians on the basis of a percentage of premiums collected, or otherwise, at a rate less than the fee schedule established by the Industrial Accident Commission; and be it further

Resolved, That a special committee of three, to be appointed by the Chairman of the Council, is hereby created to represent the California Medical Association in all matters relating to Workmen's Compensation practice, and to carry into effect the policies hereinabove set forth.

I move its adoption.

SPEAKER GOIN: We have had a motion for its adoption.

DR. BRUCK: I second the motion.

SPEAKER GOIN: Is there any discussion?

The question is on the adoption of Item Number 6, including this resolution.

DR. MADSEN: How does this conflict with or coincide with the previous Committee's report?

DR. GEISTWEIT: It really doesn't.

DR. MADSEN: You are here creating a committee which was not created by the previous resolution.

SPEAKER GOIN: It is the opinion of the Chair that there is no conflict; that the first resolution established the principle and this resolution somewhat activates that principle. So far, I don't believe there is any conflict.

DR. CASS: The first resolution gave the Standing Committee on Industrial Practice the job that this resolution is giving to a new committee.

SPEAKER GOIN: Then there is a conflict in that connection. The Chair will entertain a motion to amend this resolution by substituting for the words "special committee" the "Committee on Industrial Practice."

DR. CASS: I so move.

DR. MADSEN: Second the motion.

DR. H. D. NEUFELD (Contra Costa County): If you care to have the first resolution, I have it here.

SPEAKER GOIN: You may read it, Doctor.

Dr. Neufeld read the first resolution as presented by Reference Committee No. 1.

SPEAKER GOIN: That is quite correct. It does direct that a special committee of three be appointed by the Chairman of the Council. That would actually create

two committees doing the same job. I think that, in order to preserve Dr. Cass's amendment, the words "special committee of three" be deleted, and the words, "Committee on Industrial Practice," be substituted. That would accomplish your objective.

The question, then, is on the amendment. The *amendment is to strike out the words "special committee of three," and substitute the words, "The Committee on Industrial Practice";* otherwise, the resolution is unchanged.

Is there any discussion?

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: The amendment is carried. The question is now on the adoption of the report as amended in reference to this particular section. This section of the report includes this resolution as amended.

The motion to adopt that section of the report, including the resolution, was put to a vote and unanimously carried.

Reference Number 36: (See 12.)

Item 6. Resolution No. 8, Regarding Councilor Districts:

Resolution No. 8 was also referred to your Committee. After due consideration, your Committee recommends that a resolution be adopted as follows:

Resolved, That the House of Delegates, in accordance with the By-Law provisions, reaffirm or modify the existing arrangements of Councilor districts.

I move its adoption.

DR. CASS: I second the motion.

There being no discussion, the motion was put to a vote and unanimously carried.

SPEAKER GOIN: This section is adopted.

* * *

DR. GEISTWEIT: Mr. Chairman, I move the adoption of the Committee's report as amended.

DR. CASS: I second the motion.

SPEAKER GOIN: The question is on the adoption of the report as a whole as amended.

The question was put to a vote and the motion was unanimously carried.

SPEAKER GOIN: The report as a whole is adopted as amended.

SPEAKER GOIN: Thank you, Dr. Geistweit.

* * *

The slight conflict is due to the fact that our Constitution and By-Laws make no provision for referring the Report of the Executive Secretary. It seems logical that it should be referred to the same committee to which the report of the Secretary goes. Just for the sake of establishing a precedent, the Chair is now going to rule, the House concurring, that hereafter the *Executive Secretary's Report* shall be referred, with the Association Secretary-Treasurer's Report, to Reference Committee Number 2. Is there any dissension? If not, I think that may establish a precedent for future disposal of that report.

* * *

I will now call for the Report of Reference Committee Number 3.

Reference Number 37:

REPORT OF REFERENCE COMMITTEE NO. 3: ON RESOLUTIONS, AMENDMENTS TO THE CONSTITUTION AND BY-LAWS, AND NEW AND MISCELLANEOUS BUSINESS

(Dr. Samuel Ayres, Jr., Los Angeles, Chairman; Thomas A. Card, Riverside, and John Hunt Shepard, San Jose)

MR. SPEAKER and Members of the House of Delegates of the California Medical Association: The members of Reference Committee Number 3 want to express their thanks to the members of the Association who came before the Committee and expressed their views, pro and con, on the various items of New Business that were introduced.

The shortness of time, owing to the telescoping of the convention into two days, has made it impossible to get this work finished in time to have the resolutions mimeographed.

The Committee has attempted to summarize the resolutions in their recommendations, and in the event that anyone cares to have a resolution read in full, the resolutions are here and can be read if you so desire.

Reference Number 38:

How Annual Session Resolutions Should be Prepared:

The Committee would like to call attention to the *proper means of preparing these resolutions.* For future Committee's benefit these resolutions should be typed, double space, with three copies. The name of the introducer or the organization sponsoring the resolution should be included, as well as a brief statement of the purpose.

Some of the resolutions came in on little slips of paper, for instance, and another one came in almost all completely scratched out except for about two lines which constituted the resolution. There is no reason for leaving it to the ingenuity of the Committee as to what is wanted. It is rather important that these resolutions be in proper form in order to expedite the matter that is handled.

Reference Number 39: (See 6 and 41.)

Physicians' Benevolence Fund:

The *proposed amendment to the Constitution* amending Section 1, Article XI, having been duly presented to the House of Delegates and published according to the requirements, reads as follows:

"Resolved, That Section 1 of Article XI of the Constitution of this Association, California Medical Association be and the same hereby is amended, by adding to said Section at the end thereof, the following paragraph:

'At least $1.00 out of the annual dues paid by each member of the Association shall be allocated to the Physicians' Benevolence Fund and shall only be used for the purposes as set forth in the by-laws.'"

The Committee recommends *do pass.* Mr. Speaker, I so recommend.

DR. MADSEN: I second the motion.

SPEAKER GOIN: The question now is on the adoption of this section of the report which amends the Constitution as read in the resolution. Is there any discussion?

There being no discussion, the motion was put to a vote, and it was carried by a two-thirds majority vote.

SPEAKER GOIN: It is adopted by a two-thirds majority.

Reference Number 40: (See 3.)

Resolution No. 1 and Proposed Amendment to the By-Laws. Postgraduate Courses for Military Members and Postgraduate Fund Therefore:

This resolution provides a fund to be established by earmarking $2.00 out of each member's annual dues for an indefinite time, the money so allocated to be used in establishing postgraduate refresher courses for colleagues when they return to civilian life from the Armed Forces, in order to more properly fit them for civilian practice.

The Committee is heartily in favor of the ideas expressed in the resolution, but feels that the future needs are indefinite and that further study should be given by

the Council, and hereby recommends that the resolution be referred to the Council for further study and action. I so recommend.

Dr. Kneeshaw: I second the motion.

Speaker Goin: The question is on the adoption of this section of the report, which refers this amendment to the Council for further study. Is there any discussion?

There being no discussion, the motion was put to a vote and it was carried.

Speaker Goin: It is adopted.

Reference Number 41: (See 6 and 39.)

Resolution No. 2. Instructions for Physicians' Benevolence Committee:

This resolution simply requests specific instructions from the Council in the matters of policy of the Physicians' Benevolence Committee as to the extent of aid to be dispensed to indigent and needy physicians.

Your Committee recommends *do pass.* I so move.

Dr. Madsen: I second the motion.

Speaker Goin: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

Speaker Goin: It is carried and the resolution is adopted.

Reference Number 42: (See 7.)

Resolution No. 3. Post-War Plans on Medical Service and Social Security:

In regard to Resolution No. 3 the Committee agrees that the present period of change in our social and economic programs justifies the adoption of this resolution, which would consider post-war plans in reference to medical care and social security, and recommends that the resolution be adopted, with the elimination of the appointment of a special committee for this purpose, and in place thereof instructing the Council of the California Medical Association to study post-war problems and take whatever action may be deemed necessary.

Mr. Speaker, I so move.

Dr. Kneeshaw: I second the motion.

There being no discussion, the motion was put to a vote and unanimously carried.

Speaker Goin: It is carried and the section is adopted.

Reference Number 43: (See 8.)

Resolution No. 4. Medical Service Liaison Committee of A.M.A. in Washington, D. C.:

The Committee heartily endorses this resolution, which would in effect establish in Washington, D. C., a Medical Service Committee composed of representative doctors from the membership of the American Medical Association, headed by a competent spokesman who would be in a position to improve public relations between the medical profession on the one hand, and the general public and our representatives in Congress on the other; and who would be available for necessary information which might be required from legislative bodies. Furthermore, such a committee would be in a position comparable to the Legislative Committee of the California Medical Association in Sacramento, and could more easily keep in touch with legislation affecting health and medical problems. The committee especially desires to call attention to paragraph number 6 which states:

"6. The Committee on Medical Service shall establish and maintain an office in Washington, D. C., and shall further be empowered and directed to employ a full-time Executive Director, who shall act as Secretary of the Committee, and whose duties shall be specified by the Committee. Such Executive Director shall be a physician who has been actively engaged in the private practice of medicine for not less than five years during the previous ten years, and, furthermore, be informed and qualified to act as a Liaison Representative to said Committee."

Your Committee recommends *do pass*, and I so move.

Dr. Edward Hayes: Second the motion.

Speaker Goin: The adoption of this section of the report adopts a resolution charging the delegates from California with the duty of introducing to the House of Delegates of the American Medical Association a resolution along the lines which Doctor Hayes presented yesterday. I want what we are considering here to be clear. Is there any discussion?

Dr. Farr: I think this matter ought to be referred to the Council of the State Association. I so move.

The motion was seconded.

Speaker Goin: It has been moved and seconded that this resolution be committed to the C.M.A. Council. Is there any discussion?

Dr. Hoffman: I should like to ask if this is a motion to endorse or to order our Delegates to bring this before the House of Delegates of the American Medical Association. Is this a motion to endorse the resolution?

Speaker Goin: The actual resolution in the hands of the Committee instructs the Delegates from California to present this resolution to the House of Delegates. The pending motion is to commit it to the Council. Are you ready for the question? The question is to commit this part of the report to the Council, which Council will not meet before the delegation goes to the American Medical Association meeting.

The motion was put to a vote and the motion lost.

Speaker Goin: The motion is lost. The question now is on the adoption of this section of the report. Is there any discussion?

Dr. Molony: Let us get this matter clear. If this resolution is adopted by this House, the Delegates from California are instructed to introduce this resolution that carries in effect that this House requests the Delegates of California to vote for it, if it comes up on the floor of the A.M.A. House. This is a very big question. Theoretically, it is very fine, and I am not committing myself or urging it one way or the other. I am not for or against it, except that we all know, and you all know, the very efficient, practical application of the Legislative Committee as it is worked out in Cailfornia; but the efficiency of our machinery in California is not primarily through our Legislative Committee, but is through other sources. It is the other sources that make up the practical machinery for carrying out the wishes of the California Medical Association in Public Health matters.

If it is possible, and this is my thought in the matter, to have such a nation-wide organization or machinery to be set up by us throughout the United States, or to bring into a national basis what we practically have in California, that would be very fine, but let's look at the matter this way. Supposing we had in Sacramento such an organization, the California Medical Association had a representative and an office in Sacramento. You know very well that you would not get very far. It is only by another method that you accomplish what you are after. I warn you to be very careful about instructing your delegation from California to go back there and vote for something that may not be for the best; otherwise, you tie the hands of the delegation. It is something that requires a great deal of study. The National situation is entirely different from the State situation, and I would ask this House to be most considerate about how they vote to endorse something that has not been thoroughly studied and worked out in a national way.

SPEAKER GOIN: Is there any further discussion? Doctor Blondin.

DR. EDW. A. BLONDIN (San Diego): I move that the Delegation from California go uninstructed in this matter. I think we have confidence enough in them to know they will do the best thing.

SPEAKER GOIN: I do not think the Chair understands your motion. The same effect would be accomplished by deleting this section of the report.

DR. BLONDIN: Dr. Molony has just stated that he feels the Delegation should be instructed as to how they should vote.

SPEAKER GOIN: But, Doctor, if they were uninstructed, it would be the same as deleting this section of the report. I do not think anything is gained by adopting a motion to let them go uninstructed. I will entertain the motion if there is a second. Do I hear a second?

The motion was not seconded.

SPEAKER GOIN: The motion is lost for want of a second.

DR. EDWARD HAYES: As you will recall when I read this resolution before this body yesterday, I called attention to the fact that it had been presented to a body, meeting in Chicago on February 14th, representing 29 different states. The resolution was presented there and adopted by that body and it is to be introduced at a meeting of the House of Delegates of the American Medical Association in June in Chicago. I think there is a little ambiguity in the resolution which was presented here. We do not mean that we would ask the House of Delegates from California or the delegates from California to introduce the resolution, although it is to be introduced. All that the physician sponsors in the Middlewest want is the approval of the Houses of Delegates of the various Western state associations on what they are doing.

I might say that the American Hospital Association and the American Dental Association already have such a set-up in Washington, and there seems to be considerable demand for such a set-up on the part of the Medical Association, and requests have come from various representatives in Congress for some source by which we could furnish information on medical subjects. It is the feeling of a good many who have studied this resolution that this is the first real step by the American Medical Association whereby it would go out to take a definite stand, and make known its relationship to the public and to keep Medicine, as far as possible, out of politics.

DR. NOBLE: May I ask a question? What relation would this Committee have with the National Physicians' Committee as it now exists?

DR. KNEESHAW: That was the point I was going to bring up. That has no effect with the National Physicians' Service. That is an entirely different group. We are going to work a different plan than has been worked by the National Physicians' Service. I think you should all be informed that the officers received a letter from this Association asking for support of this movement in our House of Delegates, but that has nothing to do with the National Physicians' Service.

DR. MADSEN: Mr. Chairman, I do not think there is any member sitting in this House of Delegates at the present moment who feels differently than a few of us do about this matter. It is true that our representation in Washington has not been adequate. Whose fault it is, is a matter for this House to consider. It would seem to me fitting that right here we could memorialize our Delegates by passing this resolution endorsing this idea, but not tying their hands. We have chosen them as Delegates to the American Medical Association, because we think they are capable and competent persons to represent us there in that legislative body. I should like to, if possible, make a motion in a very short form that we endorse in principle what is contained in this resolution and memorialize our Delegates to the American Medical Association to bring about its passage as they see fit.

The motion is seconded.

SPEAKER GOIN: Your amendment deletes this section of the report which instructs the Delegates, and there will be substituted therefor *an endorsement by the House of the principle.* Is that right?

DR. MADSEN: Yes.

SPEAKER GOIN: The question is now on the *amendment.* Is there any further discussion?

There being no further discussion, the question was called for, a vote was put on the motion to adopt the amendment and the amendment was carried.

SPEAKER GOIN: The amendment is carried. The question is now on the adoption of this section of the report.

The motion to adopt the report was put to a vote and it was adopted as amended.

Reference Number 44: (See 9 and 26.)

Resolution No. 5. Proposed New Section on Public Health:

The Committee appreciates the importance of preventive medicine and public health in the practice of medicine, and in the welfare of the public in the State of California. The desirability of creating a special section on this subject, however, is questioned, inasmuch as the public health officers already have adequate facilities for exchanging their scientific observations. However, the desirability of more closely incorporating those physicians engaged in the practice of preventive medicine and public health with the main body of physicians in the State cannot be too strongly emphasized. The creation of sections of the California Medical Association has been largely patterned after similar sections in the American Medical Association. Since the American Medical Association recognizes a section known as the Section on Preventive and Industrial Medicine and Public Health, your Committee recommends that the resolution be changed to read that, instead of forming a separate section on Public Health, a section be created to be known as the *Section on Preventive and Industrial Medicine and Public Health.*

With this modification the Committee recommends *do pass,* and I so move.

DR. GREEN: I second the motion.

DR. CASS: I have already said just a moment ago when this was brought up, the Section on Industrial Medicine and Surgery does not want its name changed. It has been a very active and aggressive section. Their papers and programs are very good. We invite Public Health to come and join our section, but we do not want the name changed.

SPEAKER GOIN: Is there any further discussion? The question is now on the adoption of this section of the Committee's report to change the name of the Committee on Industrial Medicine and Surgery to Preventive and Industrial Medicine and Public Health. Are you ready for the question?

The question was called for and put to a vote.

SPEAKER GOIN: The Chair is in doubt. Please raise your hands.

A second vote was taken, the members raising their hands.

SPEAKER GOIN: The "noes" have it and the section is deleted.

Reference Number 45: (See 10.)

Resolution No. 6. Revision of A.M.A. Principles of Ethics in Relation to War and Post-War Problems:

Resolution No. 6 recommends that the Council of the California Medical Association bring before the House of Delegates of the California Medical Association at its next Annual Session a revision of the Principles of Medical Ethics of the American Medical Association to deal with war and post-war problems, and to correlate the Codes of Ethics of the various county medical societies.

The Committee is aware of social and economic changes which may make desirable certain changes in the Code of Ethics, but feels that this matter should be referred to the Council for such action as it may deem proper. I so recommend, Mr. Speaker.

DR. WARD: I will second the motion.

SPEAKER GOIN: Is there any discussion?

There being no discussion, the motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is carried and it is adopted.

Reference Number 46: (See 11.)

Resolution No. 7. On Appointment of Special Committees of Senior Physicians to Coöperate in Securing Adequate Medical Personnel for the Armed Forces:

Resolution No. 7 relates to the procurement of an adequate supply of medical officers for the Armed Forces of the United States. The intent and purpose of this resolution is considered by the Committee to be quite worthy. However, in the Committee's opinion, the Procurement and Assignment Service has already set up advisory committees in each county medical society; and unless further assistance is requested by the Procurement and Assignment Service, we can see no need for the creation of any further committees, and the Committee recommends *not pass.* I so move.

DR. GREEN: I second the motion.

SPEAKER GOIN: Is there any discussion? The question is on the adoption of this section of the Committee's report.

DR. E. EARL MOODY (Los Angeles): Wasn't there a request from the two Chairmen of the Assignment and Procurement Committees in the State to bring this matter about so as to get more men in the service. They are both here. Maybe they can answer for themselves.

SPEAKER GOIN: Dr. Pallette, what is correct? Has the Procurement and Assignment Office asked for the formation of this committee of the county societies to aid them?

DR. PALLETTE: I am perfectly willing for you to ask Dr. Fletcher. I know what it is in the South. In Los Angeles we could make that a county committee if we wanted to, rather than burden the other 13 counties with an unnecessary committee. My attitude is neutral.

DR. SCHAUPP: I think I can clarify this a little bit. The request came out from Washington that in those cases where a man is declared available by the Procurement and Assignment Service, and he does not apply for a commission in the service, the county should coöperate in bringing pressure upon him, as far as possible, to enter the service. That is not the problem of the Procurement and Assignment as it is now construed, but in each county society there will be a committee or a group instructed to see that these younger, physically able, men are induced, if possible, to join the service. Is that what you understand, Dr. Ayres? I believe that was the only clause you wanted my help on.

DR. AYRES: I will admit that the only person I spoke to on the matter was Dr. Pallette. He seemed to feel that the situation was satisfactory as it stands. No one appeared before the Reference Committee to discuss the matter. We felt it was not necessary; however, it was up to the wishes of the Delegates.

DR. SCHAUPP: I move that the motion be amended to read *do pass.*

SPEAKER GOIN: Is there a second to the amendment?

DR. SHARP (Monterey County): I second the motion.

SPEAKER GOIN: It has been moved and seconded that the words "do pass" be substituted for the words "Not Pass."

Will you read it again?

Dr. Ayres reread that section of the report.

DR. PALLETTE: I do not want to be in the position of being opposed to this. It occurs to me that it is an unnecessary thing for every county to establish such a committee. Thirteen of my fourteen counties are already cleaned out, and there would be nobody in there to go in the service. The committee might conflict with the committees we have already set up. I am perfectly willing that any county that wants a committee should have one, but thirteen out of my fourteen counties do not need it.

SPEAKER GOIN: The question is on the adoption of the amendment. The amendment is to substitute the words "Do Pass" for "Not Pass."

The amendment was put to a vote and the amendment was lost.

SPEAKER GOIN: The question is now on the adoption of that section of the report. Are you ready for the question?

The question was called for, the motion was put to a vote and it was carried.

SPEAKER GOIN: The motion is carried and that section of the report is adopted.

Reference Number 47: (See 13.)

Resolution No. 9. On Procurement of Nurses for the Armed Forces:

This resolution deals with the procurement of nurses for the Armed Forces, and states that present provisions for this purpose are inadequate, and recommends that the Delegates from the California Medical Association to the American Medical Association be instructed to investigate and take steps looking toward the establishment of a Procurement and Assignment Service for nurses.

The Committee feels that this resolution should be passed, but has felt the desirability of making a slight change in the wording as follows:

Resolved, That the Delegates from the California Medical Association to the American Medical Association bring before the House of Delegates of the American Medical Association the advisability of the establishment of a Procurement and Assignment Service for Nurses for the Armed Forces.

With this modification the Committee recommends *do pass.* I so move.

DR. WARD: I second the motion.

SPEAKER GOIN: Is there any discussion?

DR. JOHN HUNT SHEPHARD (Santa Clara County): My understanding is that the procurement of nurses is in the hands of the Red Cross.

DR. BON O. ADAMS (Riverside County): The Federal Government directs the assignment, and we have no direction in that, to my mind.

SPEAKER GOIN: Dr. Gilman will answer Dr. Adams.

DR. GILMAN: The Procurement and Assignment of nurses is not necessarily in the hands of the Red Cross. A nurse may come into the Procurement and Assignment office in San Francisco, and ask to enroll with the Red Cross, but it is not mandatory. This is the procedure in the Navy, but with the Army I believe it is different.

SPEAKER GOIN: Is there any further discussion?

DR. MOLONY: I would like to have clarified by Dr. Ayres as to whether it is the intent of this resolution that he is setting up that it be introduced into the House of Delegates of the American Medical Association by the California delegates? Will you read it again?

DR. AYRES: We did not change the intent of the resolution but merely changed slightly the wording.

Dr. Ayres then reread the resolution as contained in the report.

DR. MOLONY: That is just what it says—that the Delegates from California are to introduce and support this resolution. Now, what are we to base this resolution on, what facts and so forth? What is the need of it. I just want some information.

DR. PALLETTE: I move to amend that we approve the spirit of this resolution, and that we request our delegates to introduce such a resolution if it seems in their judgment to be opportune.

SPEAKER GOIN: Is there a second to the proposed amendment?

DR. MOODY: I second the motion to amend.

SPEAKER GOIN: The question is now on the *amendment,* which is that we *endorse in spirit* but deactivate. Are you ready for the question?

The question was called for, the motion to adopt the amendment was put to a vote and it was carried.

SPEAKER GOIN: It is carried. We will now vote on this section of the report as amended.

A vote was taken on the adoption of this section of the report as amended, and it was carried.

SPEAKER GOIN: It is carried.

Reference Number 48: (See 14.)

Resolution No. 10. Relations Between Hospitals and Nurses Regarding Working Hours and Wages:

This resolution deals with the problems arising between nurses and hospitals in the matter of wages and working conditions. Inasmuch as neither the hospital associations nor any official representatives of the nursing groups have requested the California Medical Association to intercede in this matter, and in order that there may be a continuation of the previous friendly relationships between the medical and nursing professions, the Committee considers that this resolution is not in order, and recommends that this resolution be referred to the Council for its consideration. I so move.

DR. GREEN: I second the motion.

SPEAKER GOIN: Is there any discussion?

DR. MADSEN: What is this resolution?

DR. AYRES: The sense of the resolution is that the California Medical Association take upon itself to attempt to smooth out the conflict between the nurses and the hospitals. It seems that there has been some disagreement between the nurses as to working conditions, and they have attempted to do some bargaining. The hospitals, apparently, feel it is not in order. The maker of this resolution wants the California Medical Association to take a hand in the matter, but the Committee felt it was not our business.

SPEAKER GOIN: Are you ready for the question?

The question was called for, the motion to adopt this section of the report was put to a vote, and it was carried.

SPEAKER GOIN: The "ayes" have it and this section of the report is adopted.

Reference Number 49: (See 15.)

Resolution No. 11. On Medical Service to Federal Housing Projects Located in San Diego, and Resolution Thereon from the San Diego County Medical Society:

DR. AYRES: Mr. Chairman, in consideration of Resolution No. 11, I would like to move that the House of Delegates go into Executive Session.

DR. GEISTWEIT: I second the motion.

SPEAKER GOIN: It has been moved and seconded that the House go into Executive Session.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is carried and the Chair will again appoint Dr. Madsen and Dr. Doyle to act as Sergeants-at-Arms. The Sergeants-at-Arms will proceed to clear the House, please.

A short recess was taken, during which time the Sergeants-at-Arms cleared the House and it reconvened in Executive Session.

SPEAKER GOIN: The House will now be in order, please. Will the Sergeants-at-Arms report?

DR. DOYLE: The House is in Executive Session.

Executive Session

DR. AYRES: Resolution No. 11. . . .

(Note. The minutes of the proceedings of the Executive Session of the House of Delegates are on file in the office of the California Medical Association. Delegates who were present are in position to give reports to their respective county societies.

The Council of the Association will hold a two-day session on June 19-20, at which time the various problems involved will be given careful consideration. In due course, the component county societies will be given reports thereon.)

. . . DR. AYRES: Inasmuch as the difficulties enumerated in this resolution have not been carried through the proper channels as above stated, and in view of the extreme delicacy of the public relations involved in this resolution, the Committee recommends that this entire matter be referred to the Council of the California Medical Association and to the Board of Trustees of California Physicians' Service for appropriate investigation and solution. Mr. Chairman, I so move.

DR. SHEPHARD: I second the motion.

SPEAKER GOIN: Is there any discussion?

DR. BRYANT R. SIMPSON (San Diego County): Members of the House of Delegates: We from San Diego wish to put ourselves straight with this House. We have brought to you a problem which has grown to a place that it needs attention. . . .

DR. EDWARD A. BLONDIN (San Diego): I want to tell you fellows something that amuses me a great deal. Yesterday when the San Diego delegation appeared and read our resolution we did not know your reaction. Before we came here we appeared before the members of the Council and the Trustees of the C.P.S. We talked frankly. . . .

Speaker Goin: Is there any further discussion? Doctor Powell.

Dr. Dewey R. Powell (Stockton): Mr. Speaker and Gentlemen of the House: I am in a peculiar position which has permitted me to be rather close to this whole picture, inasmuch as I am a member of the Council, being a Councilor, and, likewise, am a member of the Board of Trustees of C.P.S. . . .

It is impossible and impractical to review all of the many phases of this immense problem in detail, but I can assure you that if it is referred, as advised by the Committee, to the Council of the California Medical Association, it will receive every consideration, and in calm, cool deliberations the necessary steps will be ironed out so far as possible. We will try to iron out the irritating details in the administration and the oversights, to the end that we may coöperate with and not fight our government. (Applause.)

Dr. Eugene F. Hoffman (Los Angeles): Mr. Speaker and Members of the House of Delegates: There are two ways to discuss a problem. One is from the personal standpoint and the other is from the factual standpoint. We can always deal with generalities. I wish to use the first two methods. . . .

Thank you, Mr. Speaker, for your courtesy. (Applause.)

Speaker Goin: Is there any further discussion? Does anyone else wish the floor?

Dr. Karl L. Schaupp: Mr. Speaker and Members of the House of Delegates: With Henry Rogers and Philip Gilman I went yesterday morning to the conference with the boys from San Diego to discuss this problem. . . .

Our duty, first, is to our armed services and our next duty is to see that our men producing the goods get proper attention. Next comes our own folks at home, and if we do not coöperate with the government when we have the opportunity now, then we have no excuse if the government steps in. You know how I, this morning, stressed that the government is stepping in right and left. They have done things we never thought possible. We have heard about these agricultural workers coming out from Oklahoma, the East and the Middlewest. They will have to be taken care of. One of the Federal agencies has set up $20,000,000.00 for medical and hospital care of the migrant Mexican worker by paid physicians; where the workers are living in these units and where the areas are too small, the government is going to have this work done by contract.

It is a constant threat. I do not think the Public Health Service wants to come in. We have our chance, gentlemen. Think it over! We know this is important. I know that the men to whom I have talked from San Diego think it is important but their problem is only one. We are a big family. Some of our children are at the front and some of us cannot go, but let us look at the whole picture. It will help to cure the problem and situation throughout the State. Thank you. (Applause.)

Dr. W. Don Rolph (San Diego): Mr. Speaker and Members of the House of Delegates: I have listened intently to what Dr. Schaupp had to say, as well as others who have spoken on this subject. I think we are all in accord with Dr. Schaupp's statement that we are interested primarily in taking care of the people who are doing war work and thus do our part.

Dr. Newell Jones (Los Angeles): . . . There are some things I am still confused about. I do not know what this is all exactly about. . . .

Speaker Goin: Is there any further discussion? Is the question called for? The question is on the Committee's motion to commit this matter to the Council for consideration and action. Are you ready for the question?

Dr. Blondin: I would like the privilege of answering or opposing some of this discussion. . . .

Dr. E. T. Remmen (Los Angeles): After conference with some of the San Diego delegation it appears that, perhaps, the matter can be settled rather readily by amending the motion to refer the matter to the Council and adding thereto certain desires or wishes of the House of Delegates setting forth certain principles to guide the Council in dealing with this very vexatious problem. . . .

Mr. Chairman, I move those recommendations as an amendment to the resolution.

Speaker Goin: Do I hear a second?

Dr. Walton (San Diego): I second the motion.

Speaker Goin: The question is on the adoption of the amendment.

Dr. Madsen: I am reminded today of a couple of days some 10 or 12 years ago when we were held spellbound by a Patrick Henry who waved large volumes of books before us, and who opened the subject of compulsory health service in the State of California. In fact, I lost myself a moment ago and thought I was there again. . . .

When the resolution was offered yesterday, I certainly hung my head, but could hear in it the possibility for compromise on these two points, as Dr. Remmen has mentioned, and as covered in his motion to amend. I think there the crux of the situation hangs. . . .

I think that most of us are far-seeing, and while our steps have been sometimes crooked, and while we have tread on toes, and I will say that to the San Diego delegation, I feel we are in the right direction, so please let's not bury our heads and run at a time when we need a bargaining agent to face big national issues. (Applause.)

Dr. Ayres: Mr. Chairman and Members of the House: I would like to say a word on this proposed amendment. I appreciate the sincerity of the efforts to compromise; on the other hand, there is a tremendous problem involved in the administrative procedure. When one speaks of dealing directly with the patients in the matter of membership, therein may lie problems which have not been fully considered. I do not know what the difficulties that may be encountered in that procedure may be. . . .

I would, therefore, urge that if any amendments are to be tacked on to the motion that they be seriously considered. Personally, I would favor the passage of the recommendation of the Resolutions Committee as it was read.

Speaker Goin: Is there any further discussion?

Dr. H. Randall Madeley (Solano County): . . . I must say this discussion has been very enlightening. . . .

I would like from my own personal experiences to offer some suggestions to this body, whatever the final analysis of this matter may be. . . .

The question was called for.

Speaker Goin: The question is on the adoption of the amendment. Are you ready for the question?

A vote was taken on the amendment.

Speaker Goin: The Chair is in doubt. We will take a rising vote.

A rising vote was taken on the adoption of the amendment, with 46 "ayes" and 51 "noes."

Speaker Goin: The amendment is lost.

DR. MOLONY: I move the previous question.

SPEAKER GOIN: The question is on the adoption of the Committee's report which is to refer this matter to the Council. Are you ready for the question?

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: This section of the report is adopted. Dr. Ayres.

DR. AYRES: Mr. Chairman, that completes the report of Reference Committee Number 3. I move that the report be adopted as read and amended.

DR. MADSEN: I second the motion.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is carried and the report is adopted.

The personnel of Reference Committee Number 3 has been Dr. John Hunt Shephard of San Jose, Dr. Thomas A. Card of Riverside, and Dr. Samuel Ayres, Jr., of Los Angeles. For three or four months every year I feel like pinning medals on members of Committee No. 3. I am sure you feel as I do—that they have done a grand job. I am sure you join me in thanking them for the work they have done for us today.

* * *

I think that the House might like to know that in spite of the streamlining of our sessions, we have had 1,184 registrants; 174 for the Woman's Auxiliary and 933 attending the President's dinner last night.

Mr. Secretary: Under Unfinished Business, is there anything to bring before the House?

SECRETARY KRESS: There is no unfinished business on the table.

* * *

Reference Number 50:

Presentation of Officers:

SPEAKER GOIN: The next is the Presentation of Officers.

Vice-Speaker—Dr. Alesen, will you come forward please. *Dr. Lewis A. Alesen of Los Angeles* has been elected as your *Vice-Speaker*. Dr. Alesen of Los Angeles. (Applause.)

SPEAKER: I now have the pleasure of presenting to the House. *Dr. E. Vincent Askey of Los Angeles as your Speaker.* (Applause.)

Dr. Askey took the Chair.

SPEAKER ASKEY: Ladies and Gentlemen of the House: I do not need to tell you how much I appreciate the honor that you have conferred upon me. I know it is a tough job to follow a man like Lowell Goin. I am going to ask that you people have a little bit of confidence in me, and give me a little bit of help at this time, because I am going to need all of the help that I can get.

I take great pleasure as your Speaker in presenting to you your *new President-Elect, Dr. Lowell Goin.* (Applause.)

DR. GOIN: Mr. Speaker and Members of the House of the California Medical Association: California Medicine has no higher honor to offer to one of its members than the elevation to this office. I just simply want to indicate to you that I am indeed grateful for the honor—I am not only deeply grateful, but I am deeply honored.

Sincerely, I do promise you that whatever small talents I may have, I shall do the best I can during my tenure of office. I also want to say that I have been your Speaker for six years, and I have enjoyed every minute of it. I deeply appreciate the courtesy, the coöperation, and the forebearance of this House. I thank you all for it, and it was with a great deal of reluctance that I turned the gavel over to Dr. Askey. Thank you.

SPEAKER ASKEY: It is now my great pleasure to present to you our *new President, Dr. Karl L. Schaupp.* (Rising Applause.)

PRESIDENT SCHAUPP: There is something I would like to say to Lowell Goin that I could not have said five minutes ago. Five minutes ago I felt entirely different than I do now. I was President-Elect last year and had something to look forward to this year; but, in being inducted as President of this organization, there is a satisfaction, there is a feeling of great responsibility. None of us know what is ahead for this year, but we do know that there is going to be lots and lots of trouble; and some of it is going to be solved by the things that have happened here this afternoon. There is going to be a greater strength in this organization, not because I am President, but because this organization is more closely knit. This Council that we have had for the past few years is so strong and so sincere that I am sure that their vision in this direction will help carry out the functions of the Presidency, which without their help cannot be done.

Thank you. (Applause.)

SPEAKER ASKEY: We have now the duty of presenting to you, for his last official act, the immediate Past President of this Association, a duty which our immediate Past President, Dr. Henry Rogers, will now perform. Dr. Henry Rogers, immediate Past President of this Association. (Applause.)

DR. HENRY ROGERS: Dr. William Molony, for years past, for your very valuable service to this organization, the California Medical Association wishes to present to you a placque on which is inscribed: *"The California Medical Association presents to William R. Molony, M. D., this token of appreciation for his services as President for 1943."*

I do not think any of you have seen it, but it is a beautiful placque.

Dr. Molony was then presented with the placque.

DR. MOLONY: Dr. Rogers and Fellow Members of the California Medical Association: I am deeply appreciative of this token. I accept it with all the fervor and the graciousness and kindness which has been given me. Let me say to you this; that, as times goes on, and during this year my part of the organization will be to be known as the Past President. As such I shall have a seat on the Council and upon the Executive Committee. I will do my best to carry on for the good of the organization, and give to it what I have by way of experience and what talents I have left. And when that year is ended, if I am still with you, I shall still give to the organization all the same effort and endeavors I have tried to give in the past. Thank you very much. (Applause.)

* * *

DR. GOIN: The *Council* will convene at this table immediately following adjournment of this House. The custom of the House has been at this time to appoint the Chairman of the Council, the President and Association Secretary a committee to edit and approve the Minutes of the House. The Chair will entertain such a motion.

DR. BRUCK: I so move.

DR. MADSEN: Second the motion.

The motion was put to a vote and it was unanimously carried.

SPEAKER GOIN: It is carried and so ordered. Is there any further business to come before this House?

DR. MOODY: I believe that we should retire from Executive Session into the House of Delegates.

Dr Goin: I believe we can transact all our remaining business in Executive Session, but if you wish we will retire from Executive Session.

Dr. Moody: I so move.

Dr. Ayres: Second the motion.

Dr. Goin: It has been moved and seconded that we retire from Executive Session. Are you ready for the question?

The motion was put to a vote and it was unanimously carried.

Dr. Goin: The House has now retired from Executive Session. Is there any further business to come before this House? If not, the Chair will entertain a motion for adjournment.

Adjournment:

Dr. Ayres: I move we adjourn.

Dr. Moody: Second the motion.

The motion was put to a vote and it was unanimously carried.

Dr. Goin: The motion is carried and the House stands adjourned.

The House of Delegates adjourned at 5:30 P.M., Monday, May 3, 1943.

Lowell S. Goin,
Speaker of the House of Delegates.
George H Kress,
Secretary of the House of Delegates.

COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION: MINUTES

Minutes of the Three Hundred Seventh (307th) Meeting of the Council of the California Medical Association*

The meeting was called to order in Conference Room No. 9 of the Hotel Biltmore in Los Angeles, at 10:30 A.M., on Saturday, May 1st, 1943.

1. Roll Call:

Present: Philip K. Gilman, William R. Molony, Sr., Karl L. Schaupp, Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Frank A. MacDonald, John W. Green, and Secretary George H. Kress.

Present by Invitation: E. Vincent Askey, Vice-Speaker; Dwight H. Murray, Chairman Committee on Public Policy and Legislation; Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, Legal Counsel, and Mr. Howard Hassard, Associate; A. E. Larsen, Medical Director of California Physicians' Service; Eugene F. Hoffman, M. D., and Mr. Bryan Kelly, of California Physicians' Service.

2. Minutes:

Minutes of the following meetings of the Council and the Executive Committee were submitted and approved:

(a) Minutes of the 306th meeting of the Council, held on February 28, 1943, at Los Angeles. (Abstract was printed in C. & W. M., April, 1943, pages 237-240.)

(b) Minutes of the 180th meeting of the Executive Committee, held on February 7, 1943, at San Francisco. (Abstract was printed in C. & W. M., March, 1943, pages 129-141.)

3. Membership:

(a) A report of membership was submitted and placed on file. Total number of active members whose dues for 1943 have been paid through component county societies is 6,869, but this includes a total of 1,867 members who have been reported as being in military service. Total new members included in above is 171.

(b) Upon motion duly made and seconded, it was voted that 1,542 members whose dues have been paid since April 1, 1943, be reinstated.

(c) Upon motion duly made and seconded, Retired Membership was granted to the following members whose applications had been received in duly accredited form from their respective component county societies:

Thomas C. McCleave, Alameda County.
James Johnston, Los Angeles County.
Alice Barker-Ellsworth, Los Angeles County.
Caesar George Cahen, Los Angeles County.
A. L. Houseworth, Los Angeles County.
Francis J. Pursell, Los Angeles County.
William F. Reasner, Los Angeles County.
Lillian Ray Titcomb, Los Angeles County.
Homer S. Wilson, Los Angeles County.
Rachel L. Ash, San Francisco County.

(d) Upon motion duly made and seconded, Life Membership was granted, under Provision 4 of Article IV, Section 1(e) of the Constitution, to:

Mathew D. Pratt, Shasta County.

4. Financial:

(a) Executive Secretary Hunton submitted reports on finances. Same were received and placed on file.

(b) Upon motion duly made and seconded, it was voted that no dues be collected from members in active military service.

(c) Upon motion duly made and seconded, it was voted that no pro-rata refunds of dues be made to members who may enter military service after having paid dues for a current calendar year.

5. Death of Councilor Frank R. Makinson:

The President and Secretary were instructed to draw up suitable resolutions concerning the death of Councilor Frank R. Makinson, copy to be sent to the family, and printed in California and Western Medicine.

Upon the suggestion of Dwight H. Murray, the Secretary was instructed to write a letter of appreciation on behalf of the Council, to Assemblyman Johnson who sponsored the resolution of the California State Assembly concerning Dr. Makinson.

6. California Physicians' Service:

Discussion took place concerning the medical and hospitalization services rendered by California Physicians' Service and the Blue Cross Hospitalization groups now operating in California (Hospital Service of California, San Francisco; Associated Hospital Service of Southern California, Los Angeles; Intercoast Hospitalization Insurance Association, Sacramento).

Medical service as conducted by California Physicians' Service was then considered. Explanatory comments were made by Dr. Larsen concerning the status of the following C.P.S. contracts: (1) Full Coverage; (2) Surgical; (3) Two-Visit Deductible; (4) Rural; (5) War Housing Projects.

A summary of the above activities, as revealed in the annual report of California Physicians' Service, as of March 3, 1943, was given, it being stated that the number of professional members (physicians) on date of March 31, 1943, was 5,200; and the number of beneficiary

* Reports referred to in minutes are on file in the headquarters office of the Association. Minutes as here printed have been abstracted.

members 88,609, these being divided into sub-groups as follows:

Full Coverage	4,000
Two-Visit Deductible	38,609
Rural	5,000
Housing Projects	41,000

Monthly income of C.P.S. on March 31, 1943, was $92,898.70, and the administrative expense on the same date, $17,928.07 (19.0 per cent).

In the general discussion which followed, Councilor John W. Green read replies that had been received by him in answer to a questionnaire he had forwarded to members of his district who were residing in the Vallejo area. Dr. Larsen also commented on the conditions which had arisen in the Vallejo district.

Dr. McClendon called the attention of the Council to a proposed resolution which would probably be submitted to the C.M.A. House of Delegates by members of the San Diego County Medical Society who felt that conditions had arisen in San Diego County that were not conducive to harmony between physicians in private practice and California Physicians' Service. It was stated that the Linda Vista project had been given approval as a filtering center, and that as regards other housing projects in San Diego County, the Council of the San Diego County Medical Society was to be consulted before work could be undertaken by California Physicians' Service, but that C.P.S. had failed to observe this agreement.

The medical service difficulties which could rapidly come into being in communities of a mushroom type that are associated with wartime industries, were pointed out. Also, the inability to secure the services of near-by physicians who were in civilian practice, but who, overburdened with their own work, had practically no time for professional work that might greatly interfere with private practice.

Dr. McClendon stated that the reaction in the San Diego County Medical Society had led to the suggestion that the San Diego County Medical Society might request the California Physicians' Service to withdraw its medical service in housing projects of San Diego County.

Dr. Hoffman, of C.P.S., spoke of the large number of night calls in some of these projects, and the inability to secure physicians in private practice to accept such work.

Councilor MacDonald brought up the matter of the actuarial report that had been submitted by Mr. Ralph Nelson. Councilor MacDonald stated that the Council, more than a year ago, had requested a detailed actuarial report, and that the report which had been submitted did not fulfill the requirements outlined in the original request. Mr. Kelly, of C.P.S., stated that Mr. Nelson's report to the Trustees of C.P.S. was limited in detailed actuarial information because sufficient time had not elapsed since the change from full coverage to warrant explicit and detailed figures. Nor, he stated, could such information be secured from any other medical service plan operating in America.

Chairman Gilman spoke of a recent conference with Mr. John R. Mannix, who was to appear on the program on Sunday for a general discussion of medical service and hospitalization plans, but without any reference to California conditions.

7. Procurement and Assignment Service:

Procurement and Assignment Service was discussed, and it was suggested that in areas within the State where the quotas were not being filled, it might be well for the county societies concerned to appoint committees of senior members to aid in the work of the Procurement and Assignment Service.

8. California and Western Medicine:

Discussion was had concerning CALIFORNIA AND WESTERN MEDICINE with special relation to its typographical appearance and costs. After full discussion, on motion duly made and seconded, it was voted that arrangements be made to again place the printing of CALIFORNIA AND WESTERN MEDICINE with the former printer, the James H. Barry Company of San Francisco.

9. Study Group on Post War Planning:

Dr. Askey reported on a Los Angeles organization, "Study Group on Post War Planning," and asked advice concerning policy regarding coöperation therewith.

Upon motion made and seconded, it was voted to be the sense of the Council that Dr. Askey, as President of the Los Angeles County Medical Association, be advised that a member of the medical profession should continue as a member of the "Study Group on Post War Planning."

10. Retired Membership:

Association Secretary Kress called attention to the desirability of an amendment to the C.M.A. constitution concerning retired membership, whereby the Council would be empowered to consider recommendations received from county medical societies within twelve months after the termination of active membership. It was agreed that Secretary Kress and the Legal Counsel should prepare such an amendment for submittal to the House of Delegates.

11. Legislation:

The Chairman of the Committee on Public Policy and Legislation commented on the various public health and medical measures which had been submitted to the 55th California Legislature, in session at Sacramento, stating that none of the proposed laws, inimical to the best interests of the public health and medical standards, had much chance of enactment.

12. Legal Department:

Mr. Peart reported on the present status of the application recently made by the Association to the California Industrial Accident Commission for a revised and increased fee schedule in compensation cases. He reported that the Commission has had the application of the Association under consideration for about two months, and he read to the Council a letter recently received from the Secretary of the Commission in which it was stated that the proposed increase in medical fees will be held under advisement at least until the adjournment of the Legislature. Mr. Peart stated that in presenting the Association's application and in representing the Association before the Commission, he had been received with every courtesy and attention.

In the discussion that followed, upon motion made and seconded, it was voted that a resolution be submitted by the Council to the House of Delegates reiterating the position of the Association on the fee schedule and expressing the policy of the Association with reference to rebating and fee cutting. The Chairman appointed Dr. Donald Cass and General Counsel Peart a committee of two to draft such resolution.

13. Adjournment:

Upon motion duly made and seconded, it was voted that the next meeting would be held on Sunday morning, May 2nd, at 7:30 A.M. Adjournment, in respect to the memory of the late Frank R. Makinson, Councilor of the Seventh District, followed.

PHILIP K. GILMAN, *Chairman*
GEORGE H. KRESS, *Secretary.*

Minutes of the Three Hundred Eighth (308th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Breakfast Room of the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Sunday, May 2nd, 1943.

1. **Roll Call:**

Present: Philip K. Gilman, William R. Molony, Sr., Karl L. Schaupp, Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Frank A. MacDonald, John W. Green, and Association Secretary George H. Kress.

Present by Invitation: Mr. John Hunton, Executive Secretary; Mr. Hartley F. Peart, legal counsel; and Mr. Howard Hassard, associate; and Dwight H. Murray, Chairman Committee on Public Policy and Legislation.

2. **California Physicians' Service:**

Informal discussion took place on medical service and hospitalization problems. On motion by McClendon, seconded by Anderson, it was voted that a liaison committee of three be appointed to act on behalf of the California Medical Association with local committees of component county societies, and also with committees from California Physicians' Service and the Hospitalization Groups. It was suggested that the county societies might well give time at each meeting to a consideration of medical service problems.

3. **Industrial Accident Commission Fee Table:**

The committee consisting of Dr. Donald Cass and Mr. Peart submitted a draft of resolution on this subject to be presented to the House of Delegates. The proposed resolution as presented by the committee was approved.

4. **Adjournment:**

Upon motion duly made and seconded, it was voted that the meeting adjourn.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

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Minutes of the Three Hundred Ninth (309th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Breakfast Room of the Hotel Biltmore, Los Angeles, at 7:30 A.M., on Monday, May 3d, 1943. Later recessed to Conference Room 9 for report by Mr. Mannix.

1. **Roll Call:**

Present: Philip K. Gilman, William R. Molony, Sr., Karl L. Schaupp, Henry S. Rogers, Lowell S. Goin, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Frank A. MacDonald, John W. Green, and Association Secretary, George H. Kress.

Present by Invitation: Dwight H. Murray, Chairman Committee on Public Policy and Legislation; E. Vincent Askey, Vice-Speaker, Mr. John Hunton, Executive Secretary, Morton R. Gibbons, Sr., Mr. Hartley F. Peart, Legal Counsel, and Mr. Howard Hassard, Associate.

2. **Farm Security Administration Health Program:**

Doctor Schaupp called attention to congressional legislation concerned with the Farm Security Administration, and stated that if no appropriation is made by Congress, the health work for itinerant agricultural workers might be seriously jeopardized. It was voted that the Council send letters to California Congressmen, urging them to support legislation that would provide appropriations for the work.

3. **American Medical Association Meeting:**

Motion was made and carried that C.M.A. Delegates to the A.M.A. be instructed to submit a resolution at the June 7th, 1943, meeting of the A.M.A. House of Delegates, requesting the American Medical Association, when it decides to hold annual meetings of the Scientific Assemblies, to follow the sequence of meeting places previously approved: namely, San Francisco, St. Louis, New York.

4. **Committee on Nominations of Standing Committees:**

Chairman Gilman appointed as a committee to submit a report with nominations of members of Standing and Special Committees, John W. Green, Henry S. Rogers, and Calvert L. Emmons.

5. **Survey of Medical Service and Hospitalization Services:**

Mr. John R. Mannix, of Michigan Medical Service, whose services had been secured by the Council to make a survey of medical service and hospitalization plans and groups now in operation in California, made a tentative report on his findings. Full discussion followed. The final report by Mr. Mannix will be rendered at an early date.

6. **Adjournment:**

Upon motion duly made and seconded, it was voted that the meeting adjourn.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

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Minutes of the Three Hundred Tenth (310th) Meeting of the Council of the California Medical Association

The meeting was called to order in the Music Room of the Hotel Biltmore, Los Angeles, on Monday afternoon, May 3d, 1943, subsequent to the adjournment of the House of Delegates.

1. **Roll Call:**

Present: Philip K. Gilman, Karl L. Schaupp, William R. Molony, Sr., Lowell S. Goin, E. Vincent Askey, E. Earl Moody, Edwin L. Bruck, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Donald Cass, Harry E. Henderson, Axcel E. Anderson, R. Stanley Kneeshaw, Lloyd E. Kindall, Frank A. MacDonald, John W. Green, and Secretary George H. Kress. Absent: John W. Cline.

2. **Organization Meeting:**

(a) Philip K. Gilman was nominated as Chairman and unanimously elected.

(b) John W. Cline was placed in nomination for the office of Vice-Chairman, and unanimously elected.

(c) The following appointments were made: George H. Kress to be Secretary-Treasurer and Editor; Hartley F. Peart to be Legal Counsel; and John Hunton to continue as Executive Secretary under a three year appointment made in 1942.

(d) Chairman Gilman announced as the Auditing Committee for the next fiscal year: John W. Cline, Chairman; Edwin L. Bruck; and Lloyd E. Kindall.

3. **Vote of Thanks to Guest Speakers and Hotel Management:**

The Secretary was instructed to extend thanks to the guest speakers and to the management of the Hotel

Biltmore for their coöperation in making the 72nd Annual Session a success.

4. **Adjournment:**

There being no further business, upon motion duly made and seconded, it was voted that the meeting adjourn.

PHILIP K. GILMAN, *Chairman,*
GEORGE H. KRESS, *Secretary.*

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION

Abstract of Minutes: Executive Committee*

Minutes of the One Hundred Eighty-first (181st) Meeting of the Executive Committee of the California Medical Association

The one hundred and eighty-first (181st) meeting of the C.M.A. Executive Committee was called to order in the Music Room of the Hotel Biltmore, Los Angeles, on Monday, May 3, 1943, subsequent to adjournment of the meetings of the House of Delegates and Council.

1. **Roll Call:**

Present: President Karl L. Schaupp, President-Elect Lowell S. Goin, Speaker E. Vincent Askey, Council Chairman Philip K. Gilman, Past-President William R. Molony, Sr., and Secretary-Treasurer George H. Kress.

Absent: John W. Cline, Chairman of the Auditing Committee.

2. **Election of Chairman:**

The Secretary stated this was the organization meeting of the Executive Committee. Upon motion duly made and seconded, it was voted that John W. Cline of San Francisco be elected Chairman.

3. **Adjournment:**

There being no other business, the meeting adjourned.

GEORGE H. KRESS, *Secretary.*

Medical Journals—For Colleagues in Military Service:

In former issues editorial comment was made on a plan to forward medical journals to the Hospital Stations of Army, Navy and Air Force camps now located in California.

This work is being carried on by the California Medical Association—through its Committee on Postgraduate Activities—in coöperation with the medical libraries of the University of California, Stanford, and the Los Angeles County Medical Association.

The addresses of the three libraries follow:

U. C. Medical Library, The Medical Center, 3rd and Parnassus, San Francisco, California.

Lane Medical Library, Clay and Webster Streets, San Francisco, California.

Los Angeles County Medical Library Association, 634 South Westlake, Los Angeles, California.

If more convenient, you can send journals, via "Railway Express Agency," collect, to: C.M.A. Postgraduate Committee, Room 2008, Four Fifty Sutter, San Francisco, California. Railway Express Agency addresses: In San Francisco, at 635 Folsom (EX 3100); in Los Angeles, at 357 Aliso (MU 0261).

* Full minutes of the Executive Committee meeting have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

CALIFORNIA COMMITTEE ON PARTICIPATION OF THE MEDICAL PROFESSION IN THE WAR EFFORT†

War Casualties

U. S. Has Lost 80,000 Men in Battle Action

The Armed Forces of the United States have lost more than 80,000 men in battle casualties in 17 months of war.

This total will be increased, probably by about 5,000, officers said today, as reports not yet compiled for the last four weeks of the Tunisian Campaign add to the Army's lists of killed, wounded and missing.

Since the war began, the Navy has reported 23,955 casualties in the Navy, Marine Corps and Coast Guard; 7,218 killed, 4,683 wounded and 12 054 missing.

Army casualties reported through May 7 total 56,942 —6,076 killed, 12,277 wounded, 24,345 missing, 14,254 reported prisoners. Of the wounded, 4,000 have returned to duty or recovered sufficiently to be discharged from hospitals.

These Army totals included two lists made public today, containing the names of more than 1,000 soldiers wounded in the European, North African, Middle Eastern, Pacific and Southwest Pacific theaters. Approximately 900 of these were in North Africa.

Of the Army's total of 14,244 prisoners and 24,345 missing, all but a small number were lost in the Philippines. More than 3,000 have been reported missing in North Africa, and most of these are presumably prisoners in Italy or Germany.

A total of 4,555 merchant marine casualties since September, 1941, was reported yesterday by the Navy.—San Francisco *Chronicle*, May 18.

Medics at Front in Africa Are Real Heroes

Northern Tunisia (By Wireless.)—I hope somebody in this war writes a book about the medics at the front. I don't mean the hospitals so much as the units that are actually attached to troops and work on the battlefields under fire.

They are a noble breed. . . .

In the last war nerve cases were called "shell shock." In this war they're called "anxiety neurosis." About 50 per cent of our neurosis patients are recoverable and even return to fighting units.

A large proportion of these cases are brought about

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the State chairman on Procurement and Assignment Service, with supervision of all counties north of the fourteen southern counties.

Associate California chairman for the fourteen southern counties is Edward M. Pallette, M. D., 1930 Wilshire Boulevard, Los Angeles.

Doctors desiring to go into the Army may have their papers prepared and receive orders for physical examination from the Officer Procurement Service, 328 Flood Building, San Franicsco, in charge.

From any of the fourteen southern counties, they may apply to the Officer Procurement Service, 1418 U. S. Post Office and Courthouse Building, Los Angeles, Major M. L. Murrell, in charge. Telephone: MAdison 7411, Extension 684.

The Office of Naval Officer Procurement for the northern section of California is in charge of Capt. C. L. Arnold, U.S.N. The Senior Medical Officer is Capt. Philip K. Gilman, U.S.N.R. The office is located at Room 515, 703 Market Street, San Francisco. Telephone: EXbrook 3386, Local 46.

The Naval Office of Procurement for the southern section of California is in charge of Admiral A. Johnson, U.S.N. The Senior Medical Officer is Captain John C. Ruddock, U.S.N.R. The office is located at 411 West Fifth Street, N.W. Corner of Hill, Los Angeles. Telephone: MIchigan 8641.

by complete fatigue, by fighting day and night on end with little sleep and little to eat.

Surgeons sometimes spot neurosis cases that they suspect of being faked in order to get out of the front lines. Their system is to put these men on stretcher-bearer duty—a hard, thankless, dangerous task. If they are faking they get well quickly and ask to be returned to their regular outfits.

In the front lines you get so used to the constant boom of artillery that you stop jumping every time a big gun goes off. If you didn't you'd look like somebody with St. Vitus' Dance. However, there's another reaction—you get irritated. You get irritated in the same way you lose patience with a baby that cries all day or a dog that barks all night. The damn noise just never ends. There's hardly a second of the day when the guns aren't rolling or those ghostly shells rustling through the air.

Finally you get so bored with its consistency that you feel like jumping up in a huff and yelling:

"Oh, for God's sake, stop it!"—Ernie Pyle in San Francisco *News*, May 17.

Here Are Things That Crack Men's Minds in This War

Aboard a U. S. Hospital Ship.—(AP.)—May 23.—Shower baths and ice cream proved effective initial treatment for the first large group of American mental breakdown casualties in this war, men who cracked under heavy and steady bombardment and shelling in the Guadalcanal jungle campaign.

With baths, ice cream, rest, quiet and good food, most victims of what navy psychiatrists now term combat fatigue responded with encouraging speed, Lieutenant Commander Dana L. Farnsworth of Williamstown, Mass., said today.

In general, Dr. Farnsworth observed, high hopes were justified for the eventual full recovery and restoration to normal life of many of the Guadalcanal victims of so-called war neurosis.

As psychiatrist aboard a hospital ship, Dr. Farnsworth diagnosed and directed the first treatment for many such casualties of the Solomons action from last August until February 1. He reported his findings in a study of these cases to a conference of navy medical officers stationed in the South Pacific.

Chief among his conclusions were:

Regardless of how strong, tough and brave a man may be, in modern war eventually he will break down if subjected to "more strain than the human organism can stand, no matter how well equipped."

Shelling by enemy surface ships—a dreadful, concentrated, earthshaking barrage of heavy Navy guns was more morale shattering among our forces than aerial bombardment.

In comment on Dr. Farnsworth's report, Lieutenant Commander C. Nelson Davis of Philadelphia, advanced a theory that combat fatigue casualties among American forces might be fewer if homes and cities in the United States were under fire.

"The American fighting man can always dream of peace at home," Dr. Davis remarked. "Perhaps a lot of our boys would not break down if they did not have this escape."

In World War I the condition of combat fatigue was called shell shock. The term war neurosis later was adopted and this in turn is being replaced by the diagnosis combat fatigue.

Fundamentally, the cause of this type of breakdown is conflict in the mind. The instinctive reaction to heavy and dangerous bombardment is to run, to get away to safety. By training and principle, a fighting Marine or Navy man sticks to his post or station. He doesn't want to be a coward.

Farnsworth cited these conditions and experiences as assaulting the minds and nervous systems of men in the front lines:

Lack of sleep. Constant tension. Repeated air raids plus false alert alarms of "condition red." Poor food. Rumors that lift or depress hopes. Flares, searchlights. Seeing friends killed or wounded. Fear of death. Blasting noise. Going into the jungle to find and burn American dead.

Dr. Farnsworth declared the "precipitating factor" in 85 per cent of the breakdown cases was a "near bomb or shell explosion." In the remaining 15 per cent no such specific factor was apparent, but the men were worn out, sleepless and physically exhausted.

He reported as one example a young marine who was thrown 10 feet by a bomb explosion. The bomb blast wounded five of eight men in his squad. Thereafter the young marine would begin shouting at any noise.

When he reached the hospital ship the young marine looked and acted like a "very old man," a typical behavior among the cases Dr. Farnsworth observed. "He was suspicious, almost animal-like," the doctor related.

He beseeched Dr. Farnsworth, "You're not going to send me back into that green hell, are you?"

This marine and all other like casualties were assured right away that they would not be sent back into action until they had recovered. All were told also that they would recover.

Dr. Farnsworth said each man was given a complete physical examination. "They felt better when they were assured there was nothing physically wrong with them."

The usual attitude of officers and men toward mental breakdown cases, Dr. Farnsworth observed, is "here is a weak sister." In consequence, a sense of shame was apparent in nearly all the cases, ranging from high ranking officers to ordinary marine privates.

"Some said they wanted to go back," Dr. Farnsworth declared, "but many wanted to be told they didn't have to go back."

Extreme sensitivity to noise was demonstrated by 67 of 100 patients selected by Dr. Farnsworth for recorded study. Seventy-two experienced difficulty in sleeping. Fifty-five were subject to horrible dreams in which they relived their battle experiences.

Answering a question, Dr. Farnsworth said he had made no record on whether a majority of the breakdown cases were city or farm boys.

"I have the distinct impression, though, that most were typical small town boys, from towns of 4,000 to 50,000," he said.—San Francisco *Chronicle*, May 24.

The First Western Meeting of U. S., State Defense Aids

Job Too Big to Be Handled by Federal Organization, Says OCD Official

Yesterday's meeting of representatives of civilian protective services of the eight Western States was the first of its kind between State and Federal defense officers.

It was keynoted by Kenneth R. Hammaker, assistant director in charge of Civilian Protection, OCD, as "a realistic grassroots session" to acquaint state defense organizations with their responsibility.

"The job is too big to be handled by the Federal organization; all we can do is pass along the latest suggestions based upon overseas experience, and the States

must do the work," he declared. He asked the delegates to let down their hair.

This they proceeded to do with such gusto that he later cautioned against too much impatience in not having all the answers supplied.

H. P. Everest, assistant sector chief at Seattle, OCD, said his office served "as a bulwark between the mistakes of Washington, D. C., and local civilian defense councils. Every parachute jumper from Washington has told us that the sector office is impractical, unsound, and that's proof that Washington, D. C., doesn't know local conditions.

"Washington had a 'share-the-meat' program. We called it 'share-what-meat?' program. There wasn't any. It was silly. We need more autonomy for the sector offices," he asserted.

Fred Confer, head of the regional planning committee, submitted maps showing the location of vital installations, a majority of them within 20 miles of the seacoast.

"We recognize that the enemy is intelligent; that he will undoubtedly seek to cripple production," he said, warning that the front lines lay in the principal cities.

He revealed that no over-all planning for reconstruction of installations on a dispersal basis in event of disaster was available, but asserted that the planning map work offered the groundwork of a master plan for avoiding future concentrations. He said some of the most inflammable types of construction were adjacent to the biggest war industries "in the path of probable attack."

Major Charles Shepard, assistant OCD medical director, reported 35,000 units of blood plasma had been distributed throughout the region chiefly to hospitals in big cities and medical men in smaller communities, all subject to transfer where needed most.

He said the Civilian Air Patrol and Army air forces had arranged to transport the plasma from one city to another when needed.

"If we have enemy action, someone is going to get hurt, and we will need hospitals. Unfortunately, surveys show our hospital facilities are more than filled on the Coast.

"We have arranged for 12,000 beds in interior hospitals that can be made available immediately."

He said that experience abroad had indicated that rescue squads to remove entrapped persons from bombed buildings were most important, and that such squads would be organized in teams of 10 men under civilian auspices with the return of a representative studying latest methods of operation.

He said recently a school for medical instructors in treatment of gas injuries had been launched and that these in turn would teach the volunteer staffs.

He paid tribute to medical men, many of them elderly, who were working as civilian volunteers in addition to serving their greatly increased practices.

George L. Levison, deputy OCD director for the Ninth region, said the main problem of civilian defense was to sustain morale and enthusiasm, and that "we are not out of the woods until the war is won." He quoted a telegram from Federal Chief James M. Landis, which advised the delegates:

"We have progressed far enough to realize that problems in this field tend not to be confined within any particular political boundary, far enough to learn how to work together, and from the Federal side, far enough to realize how great an initiative as well as a responsibility must be assumed by the States."—San Francisco *Chronicle,* May 28.

PRO PATRIA

Note. The Editor will be pleased to receive letters from C.M.A. members, who in turn have heard from colleagues in military service. (The original letters will be returned after "copy" has been set in print.)

Members of the Association, who are in service with the Armed Forces in the United States or elsewhere, are also invited to write the Editor concerning their experiences. Colleagues in civilian practice will be happy to hear from them.—Ed.

(COPY)

From Mat Hosmer, MC

U. S. Navy Pre-Flight School
Athens, Ga.

May 9, 1943.

Dear George:

I just received my membership card in the C.M.A. via 384 Post. It brought to my mind the fact that I owed you a letter on the state of things here in the south. Tomorrow starts my second year on this station. I can hardly realize it as the time has gone so fast. A lot of the men are getting orders to other stations, many sea duty and outside the U. S., but so far there haven't been any for me. A year is a long time to be on one spot though so I am expecting a move most any time.

Things have been going along at about the same old rate. We are still turning out aviators at a good rate (exact number, of course, is a military secret) and I am sure we are going to hear a lot of good things from them in the near future as they are a fine bunch of boys. My fee for medical services on these boys is to be paid in Jap heads. The exact number of course depends upon the services rendered. I expect to have quite a collection in a few months.

Your JOURNAL comes in each month and I get a big kick out of the news from the west coast. I'm about the oldest wild westerner on the station, most of the men are from the south or from Texas, so needless to say they won't listen to any stories of the west. They all think this is God's country but I know otherwise.

Give my best to the fellows around the Family.

Sincerely,
LT. COM. MAT HOSMER (MC).

(COPY)

From R. S. Peers, M.C.

155th Station Hospital, A.P.O. 923
Postmaster, San Francisco

May 10, 1943.

Dear Dr. Kress:

Many thanks for my membership card which reached me two days ago. You might note my new address where I am on D.S. for indefinite period.

I have a large medical ward with an equal large turnover, finding the work interesting as well as plentiful. Major Perez from U.C. is Chief of Surgery here with Captain Kaiser, formerly of Alameda County, his assistant. I have met many West Coasters out here.

Thank you again and hello to everyone.

Sincerely,
ROBERT S. PEERS, CAPT., M.C.

(Note. Dr. R. S. Peers is the son of Dr. Robert A. Peers of Colfax, former president of the California Medical Association.)

Military Clippings.—Some news items of a military nature from the daily press follow:

Army Hospital at San Pedro, in Los Angeles County

Federal officials in Los Angeles announced today that the War Department will construct an Army hospital costing in excess of $1,000,000 in county territory adjoining San Pedro. The site comprises 77 acres. Construction will start immediately, Federal officials said, and Federal Judge Ben Harrison has issued an order granting the government immedate possession of the property.—Alhambra *Post-Advocate*, April 23.

Army Hospital at Spadra, near Pomona

An army medical unit under command of Colonel Lyle S. Powell has arrived here and is to be stationed at the government general hospital on the site of the former State Narcotic hospital, near Pomona, it was revealed today as work on the hospital progressed. . . .

Colonel Powell was enthusiastic about the hospital site, declaring it highly desirable both from the standpoint of patients who will be housed there and the unit. He was gratified over the welcome he and officers of his staff have received in Pomona.

The buildings that were a part of the State institution are being utilized, thus reducing by about one-third the estimated cost of the project as a whole, which includes much new construction. The hospital, in addition to a limited number of large central buildings, will consist of a series of barracks.

The State property, near Pomona, was leased to the army shortly after Pearl Harbor. A medical unit was stationed there for several months, after which another important army unit utilized the property.

The site consists of approximately 500 acres secluded by rolling hills and is from every standpoint said by surgeons and engineers to be one of the most ideal hospital sites that could be found. A large section of the acreage is being used for the buildings.—Pomona *Progress-Bulletin*, May 8.

Sacramento to Form an "Affiliated Hospital Unit"

James M. Landis, director of the Federal Office of Civilian Defense, on May 10th, announced Sacramento County Hospital officials have been asked to prepare to assist the army temporarily in the event it is unable to take care of a sudden influx of war casualties or some other extraordinary military necessity.

Landis said groups of physicians are being organized for this purpose throughout the country to serve the double purpose of relieving the army of the necessity for organizing its own special groups of physicians for local emergencies and of helping to conserve the dwindling supply of physicians for the civilian population.

The groups, known as "OCD Affiliated Hospital Units," will be used for military emergency purposes only in sections in which the physicians reside. Their duties will be temporary and they will be replaced by regular army officers as soon as the surgeon general of the army can make assignments.

Each unit consists of 15 doctors normally associated with a single hospital. The physicians receive reserve commissions in the United States Public Health Service. If called to duty they will receive pay and allowances of medical officers of equivalent rank in the army.

Landis said hospitals which have substantially completed organization of their units include the San Joaquin County General Hospital, the Stanford University Medical School, the University of California Medical School and the Huntington Memorial Hospital, Pasadena.—Sacramento *Bee*, May 10.

Doctors: Rural U. S. Praised

Praising the rural areas of the United States for having in many instances exceeded their quotas in contributing doctors to the nation's armed forces, the American Medical Association declared that enrollments of medical officers in the army and navy are lagging because of the failure of young available physicians in large cities to volunteer for duty. This situation is particularly prevalent along the Eastern seaboard, the Association's official magazine charged.

The fact that the armed services are not getting all the doctors they need was disclosed at a recent meeting with military authorities in Washington, the *Journal* of the American Medical Association said. The conference revealed that 6,000 doctors must be drawn from the civilian population this year.—Weaverville Trinity *Journal*, April 8.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

55th California Legislature: Report on Legislation Related to the Public Health

The 55th session of the California Legislature adjourned on May 5th, completing 71 legislative days and a period of 122 calendar days. Actual adjournment occurred on May 8th but the legislative clocks were stopped on May 5th.

The record of the Committee on Public Policy and Legislation of the California Medical Association was practically 100 per cent perfect. The California Medical Association did not sponsor any bills in this session, but supported many measures of concern to members of the profession, and vigorously and effectively opposed many other measures tending to lower professional standards and adversely affect the public health.

State Board of Medical Examiners:

Special attention and support was given to a series of bills sponsored by the State Board of Medical Examiners. Three of these were passed and have been approved by Governor Earl Warren. Two others were permitted to die after certain serious objections had been pointed out by members of the Legislature.

Assembly Bill 1171 which was an urgency measure and became effective upon approval by the Governor on May 15th was designed to speed up the procedure for examination of candidates for medical license. It permits the Board of Medical Examiners to create committees to pass on qualifications of applicants for certificates and authorizes the taking of a mail vote of the board membership upon the action or recommendations of such committees.

Assembly Bill 1174 provides a method whereby persons whose certificates have been revoked or suspended for more than one year, may petition the board for reinstatement.

Assembly Bill 1175 provides that every applicant for a certificate shall prove that a diploma or other evidence of final, successful and entire completion of instruction and training required by a school approved by the board has been issued to him. This bill and Assembly Bill 1174 will become effective on August 4, 1943.

The bills which were permitted to die were Assembly Bill 1172 relating to citations in disciplinary procedure and Assembly Bill 1173 applying to the immunity of witnesses who testify before the board in disciplinary proceedings.

All of the above bills were introduced by Assemblyman Franklin J. Potter of Hollywood, who was chairman of the Assembly Committee on Public Health.

In addition to the above Senator Jack B. Tenney of Los Angeles, introduced Senate Bill 589 providing that subversive activities or membership in parties or organizations which engage in subversive activities shall be cause for denial, suspension or revocation of licenses to practice medicine. The Senate refused passage of this bill.

Chiropody:

Opposition was presented to Assembly Bill 1110 and its counterpart Senate Bill 596, which would have removed chiropodists from licensing under the State Board of Medical Examiners and established a State Chiropody Act and a California Chiropody Society with wide powers. Both of these bills died in committee. Assembly Bill 1928 which added chiropody and chiropodists to sec-

tions of the Health and Safety Code, Labor Code and School Code relating to rights and privileges of physicians and surgeons, was also successfully opposed.

Assembly Bill 334, which would have extended the definition of chiropody to include treatment of the leg, was amended to confine the definition to the present law, but it was refused passage as was Assembly Bill 335 authorizing chiropodists to buy or order the sale of hypodermic syringes or needles.

Chiropractic:

All chiropractic bills were defeated in committee. These included proposals to permit chiropractors to treat injured employees under the Workmen's Compensation Act; to permit chiropractors to take a graduate course of 600 hours and receive the degree of graduate physician and use the title "physician"; to permit chiropractic schools to issue diplomas and certificates to "graduate nurses" and to permit chiropractors to make pre-marital and pre-natal tests and issue certificates.

Handicapped Children:

The committee on Public Policy and Legislation actively supported Assembly Bill 257 directing the State Department of Public Health to seek out children with an impaired sense of hearing and appropriating $26,500 to the department for such work. The bill having been amended to cover "especially the primary and grammar grades of all schools" and require that the Department of Public Health "in its conferences and diagnostic clinics shall employ for such diagnostic investigation trained otologists." This bill passed both houses of the Legislature and is before the governor for approval.

Health Insurance:

Assembly Bill 1079 and Senate Bill 885 covered the same schemes of State Health Insurance that were defeated in the 1939 and 1941 sessions of the Legislature. Both of these bills died in committee.

Hospitals:

The committee gave approval and support to a series of bills sponsored by the Association of California Hospitals, designed to meet changing conditions in hospital operations and service. Likewise it opposed other bills which appeared inimical to the best interests of the public and good hospital service. Particular attention was given to bills clearly defining the status of nonprofit hospitals under the Unemployment Insurance Act and to Assembly Constitutional Amendment No. 17, which will be on the ballot at the next general election, and which provides that the legislature may exempt from taxation all or any part of the property used exclusively for nonprofit hospital services.

Massage:

Assembly Bill 528, setting up a California State Board of Massage, was successfully opposed in committee.

Naturopathic:

The same old Naturopathic bill, which has been defeated in several past sessions of the Legislature and also by vote of the people when submitted as an initiative, was revived in Senate Bill 1077. This bill passed the Senate but was decisively defeated in the Assembly Committee on Public Health.

Nursing:

The committee gave its support to the nursing profession in the defeat of bills extending the scope of practical nurses and lowering the standards of nursing practice. It gave active support to Assembly Bill 326, providing for a clarification of emergency nursing service during the present war times. This bill was agreed upon by conference of the Director of Professional and Vocational Standards, the Board of Nurse Examiners, the California State Nurses Association, the Association of California Hospitals and the California Medical Association. It was approved by Governor Warren on May 18th.

Physical-Therapy:

Assistance was given the members of the California Chapter of the American Physiotherapy Association in their Assembly Bill 664 relating to the practice of physical therapy, schools of physical therapy and the registration of physical therapy technicians. This bill was bitterly opposed by the chiropractors and was extensively amended by a sub-committee of the Assembly Committee on Public Health. In its amended form, it was deemed undesirable.

Pre-Marital Examinations:

On April 24th, Governor Warren signed Senate Bill 547, relating to pre-marital examinations. This bill permits acceptance of certificates from other states having comparable laws and certificates signed by United States Army or Naval medical officer for military personnel.

Public Health Department:

One of the most bitterly contested measures in the entire legislative session was Asesmbly Bill 686 relating to the Department of Public Health. This bill sponsored by Speaker of the Assembly Charles W. Lyon of Los Angeles, required that the State Director of Public Health "shall hold the degree of doctor of medicine from an approved medical college and shall be eligible to license to practice in the State of California He shall have had in addition at least one year's postgraduate training in a school of public health approved by the State Board of Public Health, and a minimum of five years' practical experience as an administrative officer in a well organized health department."

Osteopaths promoted a powerful campaign to amend out the words "doctor of medicine" and substitute "physician and surgeon," so that members of their group might be eligible for appointment as Director of Public Health. They offered their amendments before committees of the Assembly, and again on the floor of the Assembly, but were decisively defeated. When the bill came up for hearing in the Senate Committee on Governmental Efficiency they again presented their amendment, backed by a delegation of their professional members and educators but the committee refused to accept it. They persisted until the bill was finally passed by the Senate and went to the governor. Barrages of telegrams, letters and telephone calls flooded the legislature, but to no avail as Assemblyman Lyon successfully carried his bill through both Assembly and Senate without the osteopathic amendments.

State Guard:

The entire state guard act was rewritten by Assembly Bill 1929 which was approved by the Governor on May 2nd. The act provides that the guard shall be organized "in conformity with the United States Army Table of Organizations," which would include the qualifications for the medical personnel.

Sales Tax:

Assembly Bill 1525 which would have exempted from the sales tax orthopedic, surgical, dental, ophthalmic, ocular and auditory appliances or restorations passed the Assembly with little opposition but was turned down by the Senate Committee on Revenue and Taxation.

Workmen's Compensation:

No changes were made in the Workmen's Compensa-

tion Act, from the standpoint of medical care. Assembly Bill 292, relating to percentage contracts and rebates for medical or surgical care or hospitalization, was introduced early in the legislative session under the sponsorship of organized labor. Pursuant to instructions from the Council of the California Medical Association, the Committee on Public Policy and Legislation, caused the following amendment to be offered:

"No agreement or contract between an employer or insurance carrier and any other person relating to the measure or amount of compensation for medical, surgical or hospital care rendered or to be rendered under this Division (including agreements of the character described in Sec. 5304 of this Code) shall be enforceable or of any force or effect unless (1) a complete copy thereof is filed with the Commimssion not more than five (5) days after its execution, and (2) its terms and provisions are approved by the Commission in writing within thirty (30) days of the date of filing. If any agreement or contract within the scope of this Section is not evidenced by a writing, a memorandum fully describing its terms shall be prepared and filed with the Commission in lieu of the copy mentioned above. The certificate of authority of any insurance company convicted of violation of any of the provisions of this Section shall be revoked by the Insurance Commissioner of this State in accordance with the provisions of Section 704.5 of the Insurance Code. Any persons violating any of the provisions of this Section shall be guilty of felony."

The committee also caused the same provisions to be introduced in Senate Bill 1097.

For strategic reasons organized labor decided later in the session to drop any further activity in behalf of these bills, and both acts died in committee.

Miscellaneous:

Many miscellaneous matters of interest to members of the medical profession were before the Legislature. A few of these may be mentioned.

Assembly Bill 515 appropriating $87,000 to the University of California to establish and maintain a School of Public Health which passed the Legislature and is before the Governor for action.

Assembly Bill 1077 relating to establishment and maintenance of student health services and infirmaries at state colleges, which was opposed by the medical profession and defeated in committee.

Senate Bill 145 appropriating $35,000 to the California Polytechnic School for the cultivation of herbs for medicinal and perfume purposes, passed by the Legislature and now on the Governor's desk.

Senate Bill 548 which has been signed by the Governor, permitting governing boards of school districts having less than 10,000 daily attendance to provide medical and hospital services through nonprofit membership corporations or accident insurance, to pupils injured on premises of the district.

* * *

Many other legislative matters occupied the daily attention of the Committee on Public Policy and Legislation, throughout the 122 days covered by the session, but the above are a few of the high spots. A total of 3,397 measures were introduced in the Senate and the Assembly. Over 300 of these had some reference to public health questions and required observation and attention at various times. The Public Health League of California again established an office in Sacramento for the legislative session with its executive secretary and necessary assistants on the job. This office kept the legislative committee in daily touch with all developments, which in turn were relayed to the central office, the legal department, the council and component societies for indicated action.

Public Health School

Public health authorities in California are urging passage of a bill before the Legislature to create a school of public health in the University of California. A modest budget of $87,000 is carried in the bill for setting up and operating the school for the next biennium.

The purpose of the school would be to train public health administrators. The war has done two things making such training imperative. It has taken many public health experts into the armed forces. It has created new sources of dangerous epidemic disease contagion. The net result is a greatly reduced form of trained personnel to combat a greatly increased menace.

The postwar picture is equally grave. California will be confronted by baffling social, economic and population problems when the war is over, in all of which public health will have a prominent part. Upon state and local authorities will rest responsibility for preventing a breakdown of health safeguards. Only with the help of trained experts can that responsibiilty be discharged.

There is no school in the West with a full complement of courses in public health. For the costs of the education, public health training is a most profitable investment because it is directed toward prevention of epidemics and maintenance of physical resistance, thereby avoiding the vastly greater costs of combating disease outbreaks after they become widespread.

The bill (AB 515) has been approved by the lower house and now rests in a committee of the Senate. It should be reported out for passage before the legislative session ends.—San Francisco *News*, April 28.

Battle For Health Moves Steadily Forward In U. S. A.

There are approximately 41,000,000 persons within the United States for whom no full-time public health service is provided by either local or state government. To cover this gap, the American Public Health Assaciation has proposed legislation which would enable sparsely settled areas to organize local health units.

As the *American Medical Journal* points out: "This legislation proposes that county full-time health departmemnts may be created either by resolution of a county board or by the voters of a county and that multiple county health departments may be set up. If four or more counties wish to associate themselves in establishing and maintaining such a department, prior approval must be obtained from the state department of public health.

"Provision is made for the levying of a special tax not to exceed 1 mill on the dollar on all taxable property in the county or counties involved to finance the operation of the department." The *Journal* further urged local medical societies to analyze local needs in conference with state health officers and support legislation necessary for providing local health units.

Medical men would be the last to oppose sound measures designed to extend medical service. They constantly seek new methods to combat illness and death. And the laboratory is not the only scene of battle for them. They will fight on the public platform, if need be, for proposals which they think will further the cause of health, just as they oppose measures that their training and experience tell them would hurt the cause of health.—San Jose *Mercury-Herald*, May 6.

Medical Journal Urges Parleys on Federal Control

Chicago, April 29.—(UP.)—The *Journal* of the American Medical Association today suggested the immediate establishment of a government agency to handle post-war nutritional and medical problems.

"Certainly," the magazine said in an editorial, "the time is not too soon to suggest that the government of the United States establish as soon as possible a mechanism for giving these questions the analysis and consideration that they may deserve and for suggesting the steps that may be followed under a democratic government for their solution."

The editorial mentioned proposals made in the Beveridge plan in Great Britain and in the report of the National Resources Planning Board in this country and reported that the Council of the British Medical Association felt that the profession would be opposed to a complete system of state medicine.

"Here in the United States," the editorial continued, "representatives of American business and the other professions have begun to realize that the tossing of medicine as a sop to the proponents of state medicine is merely a concession which does not delay but rather gives impetus toward complete socialization and destruction of private enterprise."—Long Beach *Telegram*, April 25.

COMMITTEE ON MEDICAL ECONOMICS

Concerning Wage and Hour Order of Industrial Welfare Commission

Reference was made in this column in March to the new wage-and-hour order issued by the Industrial Welfare Commission of the State of California. Word has now been received that this order will not become effective until June 28, 1943; this gives a little more time to adjust conditions which might not come up to the standards set in the order.

In the March issue it was inadvertently stated that the basic provisions of the Industrial Welfare Law of California prohibited the employment of women employees before the hour of 6 a.m. or after the hour of 10 p.m. That statement should be amended to show that this provision covers only minor employees, under the age of 18 years, but does not apply to adult women employees. The law states that if women are employed after 10 p.m. or before 6 a.m., suitable transportation between their homes and places of employment must be available.

As regards physicians' offices, it should also be pointed out that the law excepts "professional occupations" from the hour provisions. This exception has been interpreted to apply to registered nurses, who may be called upon for employment of more than 48 hours a week or during night hours, even though they might not be more than 18 years of age.

COMMITTEE ON ASSOCIATED SOCIETIES AND TECHNICAL GROUPS

Pacific States Medical Executives' Conference

The fifth annual session of the Pacific States Medical Executives' Conference, originally brought into being under the auspices of the California Medical Association, was held in Portland, Oregon, on Saturday-Sunday, May 29-30, 1943, with headquarters at Hotel Benson.

The affiliated state medical associations are those of California, Nevada, Oregon, Washington and Idaho.

The California Medical Association was represented at the Conference by Council Chairman Philip K. Gilman, Henry S. Rogers, Past President, and Secretary-Editor, George H. Kress.

Program follows:

(COPY)

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE

Fifth Annual Session

At Hotel Benson, Portland, Oregon

May 29-30, 1943

Affiliated Associations: California, Nevada, Oregon, Washington and Idaho State Medical Associations.

PRESIDENT PHILIP K. GILMAN

Captain, Medical Corps, U. S. Naval Reserve

San Francisco, California

Presiding

PROGRAM

Saturday, May 29th

6:30 P.M. Dinner Session.....Rose Room

Greetings from the Oregon State Medical Society. George E. Henton, Portland, Oregon, President.

"The Procurement and Assignment of Medical Officers."

Discussion to be opened by Philip K. Gilman, Captain, Medical Corps, U. S. Naval Reserve, Office of Naval Officer Procurement, 12th Naval District, San Francisco, California.

Sunday, May 30th

10:00 A.M. Morning Session.....Room 204

"Programs of Maternal and Infant Care for the Wives and Infants of Enlisted Men through Federal Grants-in-Aid to the States."

Discussion to be opened by Arthur Anderson, Executive Secretary, Washington State Medical Association, Seattle, Washington.

"Organization, Progress and Problems of Medical Service Plans Sponsored by the State and County Medical Societies."

Discussion to be opened by Willard C. Marshall, General Manager of the Oregon Physicians' Service, Salem, Oregon.

"Features and Trends of Blue Cross Hospital Service Plans Affecting Medical Service Plans and Medical Practice."

Discussion to be opened by George H. Kress, Secretary-Editor, California Medical Association, San Francisco, California.

12:30 P.M. Luncheon.....Rose Room

Business Session immediately following.

2:00 P.M. Afternoon Session.....Room 204

"Medical Service Plans in War Industrial Centers and Federal Housing Projects."

Discussion to be opened by George H. Kress, Secretary-Editor, California Medical Association, San Francisco, California.

"Medical Service Plans for Farmers and Agricultural Workers."

Discussion to be opened by Henry S. Rogers, Past-President, California Medical Association, Petaluma, California.

"State Legislation Affecting the Public Health and Medical Practice."

Discussion to be opened by Arthur Anderson, Executive Secretary, Washington State Medical Association, Seattle, Washington.

4:00 P.M. Adjournment.

* * *

Resolutions adopted on May 29-30, 1943, at the Fifth (5th) Annual Session in Portland, Oregon, Philip K. Gilman, California, presiding.

The Reference Committee (George E. Henton, Oregon, Chairman, Homer D. Dudley, Washington, and George H. Kress, California) presented the following resolutions:

1. *Resolved*, That approval be expressed of *federal assistance to the wives and children of service men* as outlined in the plan under consideration by the Federal Children's Bureau; provided, however, that the constituent state medical associations which are members of the Pacific States Medical Executives' Conference be requested to consider carefully the merits of the procedure proposed by the Oregon State Medical Society, wherein any allocations for professional services agreed upon as compensation for obstetric work involved shall be given to the wives of enlisted men, such patients then to secure the services of physicians as they themselves deem proper, the fee for professional services to be decided by mutual agreement between the patients and the attending physicians; and

Resolved, That the Conference Secretary send outlines of the Oregon plan to the constituent state associations; and further

Resolved, The suggestion be made that a special committee composed of representatives of the Pacific States medical associations be brought into being if possible, to further consider the above Oregon plan.

2. *Resolved*, That the Pacific States Medical Executives' Conference refers for careful consideration of constituent state medical associations which to date have not filled their quotas for military personnel, the plan of setting up in local communities *special committees of senior physicians* who will coöperate with procurement and assignment service committees, in having eligible physicians make applications for commissions to the Armed Services.

3. *Resolved*, That the Pacific States Medical Executives' Conference recommends for consideration to the respective constituent state medical associations, the desirability of informing *physician members who are specialists*, concerning the importance of accepting as much general practice work as possible, in order to relieve the heavy work now falling on the shoulders of their fellow practitioners.

4. *Resolved*, That the Pacific States Medical Executives' Conference recommends that the respective constituent state medical associations carry on a campaign of publicity among members, emphasizing the importance of *eliminating luxury hospital care and optional nursing* as much as may be possible; inasmuch as through such coöperation it will make available hospital beds for a larger number of citizens, especially war industrial workers, who may be in great need of such hospital and nursing care.

5. *Resolved*, That the Pacific States Medical Executives' Conference recommends to the respective state medical societies the desirability of having their respective delegates call to the attention of the House of Delegates of the American Medical Association the nature of many of the *medical service problems which have come into existence in Pacific States* and other communities that are carrying on extensive war production activities, to the end that over-all plans may be brought into being that will aid in the prevention of medical service complications that may otherwise arise.

6. *Resolved*, That the Pacific States Medical Executives' Conference recommends to the constituent state medical associations which maintain official publications, the desirability of placing on the *complimentary mailing lists* the names of the presidents and secretaries of each of the constituent state medical associations represented in this Conference; in order to permit such officers to have more available from month to month the official proceedings of their neighboring state medical organizations.

7. *Resolved*, That it is recommended that the Executive Committee of the Pacific States Medical Executives' Conference set the *date of the annual meeting of this Conference* sixty to ninety days prior to the annual meeting of the House of Delegates of the American Medical Association in order that the constituent state associations represented in the conference may be better prepared to give advices to their respective delegates.

After discussion, section by section, each of the above resolutions was unanimously approved by the representatives from the States of Washington, Oregon, Idaho and California.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

On California Nursing Personnel Needs

Medical services are being rationed. Medicine "as usual" is out. Likewise nursing service is necessarily being curtailed.

The relation of the supply of nurses to the demand for nursing service repeats a pattern grown painfully familiar in our national economy.

The striking increase in hospitalization promises even greater acceleration because of industrial expansion and the development of target areas, such as we have in (California) (San Francisco Area).

More nursing service is being demanded by the Army and Navy and these demands must be met. To meet the needs at least three of every five of those nurses now eligible must join the armed forces.

As physicians we must help design measures to guarantee most effective use of the nursing service at hand.

We know that a part of the service now given by graduate and student nurses could be given by personnel with less costly training. Heavier loads must be borne by nurses all along the civilian front. The precious supply of available nursing service must not now be used for the performance of nonnursing activities, but must be hoarded for use in situations which demand expert technical service.

The following letter has been submitted by representatives of the Nursing Profession:

How Physicians May Aid in Promoting Adequate Nursing Care for Patients:

In order to conserve nursing service so that physicians will receive the best assistance and at the time when it is most essential, and in order that the seriously ill patients will be assured safe nursing care, I ask you, my fellow physicians, to consider methods by which we can make a real contribution and one which will reflect itself in better service to our patients.

1. The services of private duty nurses should be reserved for acutely ill patients and for patients who require special treatments which can be given safely by registered nurses only, and for situations where the character and limited amount of nursing service available for patients makes it necessary for private duty nurses to be employed.

2. Physicians should advise patients as to the most effective use of nursing service, and appeals should be made to the public to refrain from employing two or three special nurses for one patient during the period of convalescence.

3. Hospitals should be urged to make provision for group nursing (one nurse caring for two or more hospital patients) and for hourly appointment nursing service in homes.

4. Use should be made of auxiliary nursing personnel for nonnursing activities.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Northern California Public Health Association

Election of Dr. W. A. Powell, Contra Costa County health officer, as president of the Northern California Public Health Association, was announced on May 26th, as the second and concluding session opened at Hotel Claremont in Berkeley.

Other new officers are: Dr. Dwight Bissell, San Jose city health officer, president-elect to succeed Dr. Powell in 1944; Walter Mangold of Berkeley, U. C. sanitarian, vice-president, and Mrs. Helen Hartley of the San Joaquin local health district, treasurer. Mrs. Ann W. Haynes of the San Francisco office of the State Department of Public Health was reëlected secretary.

The retiring president, Dr. John D. Fuller, Santa Cruz County health director, was elected to the governing council of the American Public Health Association, and Dr. Malcolm H. Merrill, chief of the State Health Department laboratories, Berkeley, named representative to the western branch of the APHA executive committee.

At a panel on streamlining programs and personnel for the war, the Berkeley program, directed by Dr. Frank Kelly, city health officer, was described as one of the models in the nation although the city has only one public

health nurse for each 5,000 inhabitants against the accepted ratio of one for each 2,500.

Southern California Public Health Association

Outstanding public health officials of the United States and England were present on May 24th at the Pasadena Civic Auditorium to participate in a public health conference which will concentrate on wartime health problems.

The conference was originally scheduled for San Francisco but was moved to Southern California under the auspices of the Southern California Public Health Association, of which Dr. George M. Uhl, city health officer of Los Angeles, is vice-president.

All-Day Session

The conference commenced at 10 a.m.

The theme of the afternoon session was "Medical Care During the Emergency and Postwar Periods," and included the following speakers: Dr. Nathan Sinai, University of Michigan; Dr. Edith Sappington, United States Children's Bureau; Dr. Don Gudakunst, National Foundation for Infantile Paraylsis; Dorothy Deming, R.N., American Public Health Association.

Briton to Speak

In the evening Dr. Herbert Hughes Parry, Bristol, England, spoke on organizing a city against an air raid, and Dr. Albert McGowan, medical director of the American Red Cross, discussed "The Red Cross in a Wartorn World."

Other speakers of the day were Dr. W. L. Halverson, State Director of Health; Dr. John L. Rich, health officer of New York; Dr. H. O. Swartout, health officer of Los Angeles County; Dr. E. R. Coffey, United States Public Health Service, and Dr. Uhl.—Los Angeles *Times*, May 24.

County Charities to Cost $51,000,000 Next Year

Relief Rolls and Share of Aged Help Less, but Expense Estimated at $51,000,000

While there has been a decline in certain kinds of public relief, during the coming fiscal year it will cost the taxpayers of Los Angeles County approximately $51,000,000 to finance the various types of charity administered by the county government. . . .

The decrease is due, according to Arthur J. Will, head of county institutions, to a greatly reduced number of persons on the indigent relief rolls.

Will said that operation of the General Hospital, Olive View Sanatorium, Rancho Los Amigos and other institutions will cost $12,000,000 during the new year. Other welfare activities such as old age aid, indigent relief, aid to crippled children and the blind will cost: $39,000,000. . . .

At present there are 65,000 aged aid recipients in Los Angeles County. Liberalized rules of eligibility for obtaining the aid will jump the figure to 85,000, it was asserted by welfare officials.—Los Angeles *Times*, May 17.

Doctors for Farmers

Current attacks on Farm Security Administration threaten to undo one of the most effective programs of the New Deal. If Congress succeeds in stripping FSA of funds, there will be an end of the medical care program, which has brought "group health" to 117,000 families in the lower income classes of the country.

At first, this program was bucked by the American Medical Association which worried about "socialized medicine." But after six years a recent report of the conservation Medical Association views the experiment with favor.

Reason for the change is that state medical associations, in the proportion of about four to one declared that the group health program did not destroy the independence of doctors, but actually gave them more business.

The Farm Security medical plan is a "prepayment plan," under which families in farm areas pay a fixed fee for a full year's medical care for the entire family, regardless of what ailments may develop. The fee ranges from $15 in the poorer areas, upwards to $40.

But the farm bloc, now running wild in Congress, probably will sweep aside this aid to rural communities, though it now operates in 1,140 counties. Incidentally, most Congressmen don't even know this medical service exists.—From Drew Pearson's "Merry-Go-Round" in Hanford *Journal*, April 22.

Board Indorses Hospital Drive

Indorsement by the Board of Supervisors of the United Hospital Fund campaign to provide 800 beds and other facilities in eight local nonprofit hospitals was announced yesterday by T. R. Knudsen, general chairman of the $3,000,000 campaign.

Knudsen also announced that the executive council of the Church Federation of Los Angeles has indorsed the appeal.

The eight hospitals to be expanded as a result of the campaign are: California, Good Samaritan, Hollywood Presbyterian, Methodist, Monte Sano, Queen of Angels, St. Vincent's and White Memorial.—Los Angeles *Times*, May 18.

Rationing Has Aided British, Doctor Claims

Health Association Hears Praise for 'Plain' Foods

Food rationing has done the British more good than harm in removing luxuries and supplying plain, wholesome nourishment, according to Robert Hughes Parry, doctor of public health, Bristol, England, who addressed the Southern California Public Health Association last night at the Civic Auditorium.

Speaking before 300 persons at the one-day session of the association, Dr. Parry gave credit for England's staunch resistance to war to her homes and her women folk.

Homes Attractive

"We have come to believe that the reason we have put up with what we have in this war is because we had homes where children can see flowers growing, homes that are built with the idea they must serve as a workshop to the nation's mothers.

"Between the last two wars 36,000 new homes were built for the working classes and between 7,000 and 10,000 unfit ones were torn down."

Dr. Parry said the first jolt to the stability of these homes occurred when the young men went to war, but he praised the "tenacity and bravery of the women, who shouldered the extra responsibilities in the homes and have served as fire fighters, ambulance drivers, in industry, the army and air force."

Juvenile delinquency has increased 41 per cent among children under 14 years of age, and 22 per cent among those between 14 and 17.

"But we mustn't take this too seriously because we have found in England that about 90 per cent of the war-delinquent children turn out to be good citizens."

Favors Small Shelters

He said steel tables as home air raid shelters or small neighborhood shelters housing from 20 to 50 persons have proved more satisfactory than the large mass shelters. The steel tables will support a two-story building if it collapses.

"It's a pleasure to see the energy and cheer with which you face your health problems in America. We have heard less grumbling in England the past four years, because we have come to realize that we have been asking for this trouble and have made up our minds that our descendants will not be allowed to suffer from the mistakes of this generation."

Dr. Albert McCown, Washington, D. C., medical director American Red Cross, reviewed the history and service of the organization and praised Pasadena for "pooling its resources," and for the coöperation between the Red Cross and Civilian Defense groups.

Five hundred attended an afternoon meeting at which Dr. Reginald M. Atwater, executive secretary, American Health Association, and Dr. Nathan Sinai, professor of hygiene and public health at University of Michigan, were speakers.

Round tables on methods of solving present and future public health problems in which outstanding health workers attending the meeting participated, concluded the afternoon session.

Charles W. Arthur, Pasadena health officer and president Southern California Public Health Association, presided throughout the day and evening.—Pasadena *Post*, May 25.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (14)

Alameda County (2)

Buehler, Lyle H., *Niles*
Meadoff, Nathan, *Oakland*

Contra Costa County (2)

McNerney, H. W., *Richmond*
Rampoldi, Henry D., *Martinez*

San Bernardino County (1)

Shannon, Gizella W., *Patton*

San Diego County (1)

Robertson, Cornelia F., *San Diego*

San Luis Obispo County (1)

Treadwell, Richard T., *San Luis Obispo*

Shasta County (1)

Mackintosh, William A., *Project City*

Ventura County (4)

Huff, William Cloyce, *Oxnard*
Kelley, William Travis, *Ventura*
Ridge, Gerald K., *Ventura*
Vincent, Ward R., *Ventura*

Yuba-Sutter County (2)

Lawton, Floyd B., *Eureka*
Samson, Pieter, *Marysville*

Transfers (1)

Johnson, William C., from Monterey County to Kern County

Retired Members (10)

Ash, Rachel L., *Los Angeles County*
Barker-Ellsworth, Alice, *Los Angeles County*
Cahen, Caesar George, *Los Angeles County*
Houseworth, A. L., *Los Angeles County*
Johnston, James, *Los Angeles County*
McCleave, Thomas C., *Alameda County*
Pursell, Francis J., *Los Angeles County*
Reasner, William F., *Los Angeles County*
Titcomb, Lillian Ray, *Los Angeles County*
Wilson, Homer S., *Los Angeles County*

Life Members (1)

Pratt, Mathew, *Shasta County*

In Memoriam

Beattie, John Irving. Died at San Jose, May 7, 1943, age 59. Graduate of the Cooper Medical College, San Francisco, 1905. Licensed in California in 1906. Doctor Beattie was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Cahen, Caesar George. Died at Los Angeles, April 29, 1943, age 58. Graduate of the University of Southern California School of Medicine, Los Angeles, 1909. Licensed in California in 1909. Doctor Cahen was a retired member of the Los Angeles County Medical Association, and the California Medical Association.

Horn, Frank Ignatius. Died at Los Angeles, May 6, 1943, age 68. Graduate of Magyar Királyi Pázmány Petrus Tudományegyetem Orvosi Fakultasa, Budapest, 1894. Licensed in California in 1938. Doctor Horn was a member of the Los Angeles County Medical Association, and the California Medical Association.

✣

Makinson, Frank Roscoe. Died at Oakland, April 18, 1943, age 58. Graduate of the Oakland College of Medicine and Surgery, 1913. Licensed in California in 1913. Doctor Makinson was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Michael, Luther. Died at San Leandro, April 25, 1943, age 80. Graduate of the Medical College of Ohio, Cincinnati, 1884. Licensed in California in 1894. Doctor Michael was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✣

Woolf, Montague Sidney. Died at San Francisco, April 20, 1943, age 58. Graduate of the Royal College of Physicians of London, 1914. Licensed in California in 1918. Doctor Woolf was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✣

OBITUARIES

John Irving Beattie
1883—1943



Doctor J. Irving Beattie, President of the Santa Clara County Medical Society, passed away May 7, 1943, after a short illness. Dr. Beattie was born in Canada, received his college education at the College Institute, Ontario, Canada, and his M. D. degree from Cooper Medical College in 1905, after which he spent eighteen months in London and six months in the French Hospital in San Francisco. With the exception of his military service as a First Lieutenant in World War I, he had been in continuous practice in Santa Clara County since 1907.

Dr. Beattie was an outstanding example of a true general practitioner of medicine. Exceptionally competent in the diagnosis and treatment of the vast majority of human ills, quick to recognize the unusual case requiring special study, he was always prompt in seeking consulta-

† For roster of officers of component county medical societies, see page 4 in front advertising section.

tion thereon. His honesty and frankness and his sympathy and understanding of the varied problems of life endeared him to his very large clientele. His kindly consideration and willingness to assist his fellow practitioners, especially the young man just entering practice, were outstanding, and their regard for him was shown by electing him to the Presidency of the Santa Clara County Medical Society.

Dr. Beattie was a tireless, ceaseless worker, rarely sleeping more than five hours a day, and spending little time in recreation. A regular attendant at medical meetings, local, state, and national, he kept in close touch with the advancement of medical science, and each succeeding year found him in the front ranks of his profession.

His final illness was brief, only six weeks, a blessing too frequently denied the self-sacrificing worker. No longer will he hear the call of the distressed, the anxious parent, nor the crying child. No longer will his smile and hand-grasp greet us all, but in the hearts of the thousands whom he served, and among his colleagues, the memory of J. I. will never dim.

✤

Frank Roscoe Makinson

1885—1943

Resolved, By the Council of the California Medical Association, that in the death of Frank R. Makinson, the California Medical Association has lost an unselfish and able worker for scientific and organized medicine; who, as the Councilor representing Alameda and Contra Costa Counties and as Chairman of the Committee on Public Health Education had rendered most efficient service; and be it further

Resolved, That the Council, on behalf of the California Medical Association, place on record this recognition of his great personal and professional qualities and worth, and extends, to the members of his family, deepest sympathy in their great loss.

PHILIP K. GILMAN, *Chairman*,
GEORGE H. KRESS, *Secretary*.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. CHARLES C. LANDIS.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM..Asst. Chairman on Publicity

Annual Session Address of the President*

MRS. F. G. LINDEMULDER
San Diego

Mr. Chairman, President Molony, Members of the California Medical Association and Guests:

The Woman's Auxiliary to the California Medical Association deeply appreciates the opportunity granted its President, to appear before your general session and to tell you about the activities of our organization. The vast majority of you are our friends and well wishers, and realize the service possibilities of the Auxiliary. But perhaps there is a small minority of you that do not quite understand our aims and objectives or how we are attempting to help you, our parent organization. We are organized for your benefit and are awaiting the opportunity to serve you.

Despite the fact that many of our members have left their homes to be with their husbands as long as possible before they go overseas, we still have twenty-nine County Auxiliaries with a total membership of 1,857. One Auxiliary, because of its large loss in members, disbanded and one affiliated with another Auxiliary.

Due to the war emergency, we have emphasized projects that not only assist the war effort, but still have a direct connection with what our Auxiliary has always stood for: "To bring its members into more active affiliation with organized medicine; to encourage kindly social relationships; to coöperate with the California Medical Association and its component County Societies and other organizations in all desirable public health and social welfare work."

The Woman's Auxiliary has placed 374 subscriptions to *"Hygeia"* this year and one of our Counties has exceeded its quota.

We have given of our time and energy to the Basic Science Act, and placed speakers, distributed pamphlets, written letters, informed lay organizations of the importance of the bill, and distributed all letters to the physicians and dentists, who in turn, were to send or give them to their patients. I am sure that the Public Health League of California would be glad to endorse my statement when I say it was no fault of the Auxiliary that the bill was lost.

Many of our Auxiliaries have supported their local Blood Banks, one, with a membership of twenty-one, completely maintains a Blood Bank even to owning the building it occupies. Another maintains the Motor Corps and Canteen Corps, and for a time furnished the technicians for their Blood Bank from their membership. There have been "Auxiliary Days" at several of the Blood Banks throughout the State, when members were blood donors.

In Red Cross and Defense work, our members are doing an extremely fine job. We are represented in almost every phase from airplane spotters to Ration Board workers. County Auxiliaries have completely furnished recreation rooms for various camps and hospitals. They have furnished food and entertainment at Hospitality Houses. Thousands of hours have been given to Red Cross work, many of Auxiliaries having their own day when they furnish all the workers. One County has complete charge of a Red Cross Unit where they specialize in work having a direct bearing upon the needs of the medical man in the Service.

The sum of $750.00 has been given to Student Loan Funds throughout the State, for the benefit of medical students and nurses.

We have attempted to keep ourselves abreast of the times by having programs on medical discoveries as well as on Nutrition and Health Defense, so we in turn, could inform the lay public. We have worked in conjunction with the National Cancer Control program, placed donation cans, mailed literature, and furnished speakers to lay organizations. We have advocated annual physical examinations for women.

One of our main projects this year has been to raise money for the Medical Benevolent Fund of the California Medical Association. Los Angeles Auxiliary has donated $290.00 this year to the Physicians' Aid, but the rest of the Auxiliaries wish to donate what they

† Prior to the tenth of each month, reports of county chairmen on publicity should be sent to Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

* Address of the President, given at the first general meeting of the Seventy-second Annual Session of the California Medical Association, Los Angeles, May 2-3, 1943.

have raised to you. So in appreciation of the splendid help and coöperation we have received from the Medical Association, it is my pleasure at this time, Dr. Molony, to present to you on the behalf of the Woman's Auxiliary to the California Medical Association, this check for $1,000.00 to be applied and used as the Medical Association sees fit, for Medical Benevolence.

News Items

The subject of providing aid for the Infirmary and Emergency rooms at the Army Post in Eureka was considered at a meeting of the Woman's Auxiliary to the Humboldt County Medical Association on May 3. At that time it was unanimously decided to sponsor a play reading by Mrs. Gordon Manary of Scotia for this purpose.

During the first week of June, Auxiliary members will be joint hostesses with members of the Women's Club of Service Officers at the Eureka U. S. O. Center. Mrs. Don R. Austin and Mrs. John N. Chain are in charge of arrangements.

The Woman's Auxiliary to the Los Angeles County Medical Association met on March 23, for a social hour followed by a business meeting and Tea. Eighty-five members attended the event, which was held at the Los Angeles Medical Association Building. Mrs. Franklin Farman presided.

Announcement of the formation of the new Surgical Dressing Unit in downtown Los Angeles was made. Mrs. Donald Charnock and Mrs. Verne Soper will act as supervisors for this project. Members were urged to lend their support by giving a day a week to it. There is still a great need for workers in the Auxiliary's Red Cross Unit, the work of which is carried on at the County Medical Building.

Mrs. William C. Boeck, Chairman of the Nominating Committee, announced the following slate of officers and directors for next year:

President, Mrs. William R. Molony, Jr.
First Vice-President, Mrs. Hubert T. Wilken.
Second Vice-President, Mrs. Ludwig L. Kaftan.
Secretary, Mrs. John E. Short.
Treasurer, Mrs. C. R. Gailmard.
Directors: Mrs. Horace H. McCoy, Mrs. Herbert Movius, Mrs. Ward Rolland, Mrs. Roy Robert Miller, Mrs. F. X. McDonald, and Mrs. Joe Zeiler.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

Commercial (April, 1943)	45,300
Rural Health Program	5,000
War Housing Projects (approximate)	43,050
Marin	6,050
Los Angeles	7,800
San Diego	12,600
Vallejo	15,400
San Francisco	1,000
Total	93,350

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Acquisition of new members in industrial groups is beginning to hit an upswing after almost a year of just about holding our own. This is the fundamental of C.P.S.'s activities.

The plan for most of the housing projects is probably to be regarded as a wartime endeavor which may suddenly disintegrate. Were this our only activity, C P.S. would then find itself in a difficult position. The beginning recovery in groups of five or more, scattered throughout the state, is therefore to be regarded as a good sign. It is the cushion upon which the plan will bounce if and when the "temporary emergency" program is no longer necessary. With some 2,000 groups ranging in size from five to several thousand now producing a reasonable unit value, this phase of the program, while still too small in actual numbers, would nevertheless be sufficient to keep the administrative structure together.

With constant exposure to the public, and with the wide publicity C.P.S. is beginning to receive by reason of its contribution to the war effort (through medical care for war workers in Housing Projects) there is appearing an increasing evidence of confidence on the part of the public which should help further development in this field.

* * *

(COPY)

May 20, 1943.

Dear Doctor:

Some time ago the War Department in Washington, D. C., by command of Lieutenant General Somervell, notified its Pacific Coast Departments, advising them to get in touch with "Group Health Organizations" in their community in order that civilian employees might have the opportunity to participate. California Physicians' Service has had many calls and is now providing care for the civilian employees of Letterman General Hospital, Camp Roberts, San Francisco Medical Depot, U. S. Engineers, and many other War Department groups. We are quite proud that California Physicians' Service has been selected to furnish this care to these employees.

In our last statement we described the Two-Visit Deductible contract. Our other contract, the *Straight Surgical,* provides service from the date the operation takes place. The member is responsible for *all calls* up to the date the operation is performed. Then California Physicians' Service assumes the responsibility. This contract costs the employee considerably less than the Two-Visit Deductible.

May we have your questions or suggestions on these monthly reports, as it is our desire to keep you informed.

Financial operations for March were as follows:

Membership Dues collected	$51,871.62
Professional Member Registration Fees	60.00
	$51,931.62
Cost of Administration	11,281.03
Available for March business	$40,650.59
X-ray and lab. on hospitalized patients	3,075.43
Available for remaining professional services	$37,575.16
22,097.1 units of service at $1.75	38,669.92
Transferred from Unit Stabilization Fund	$ 1,094.76
Previous balance in Fund	30,717.06
Total Unit Stabilization Fund	$29,622.30

A. E. LARSEN, M. D.
Executive Medical Director.

(Ed. Note. For special article on C.P.S., see page 330.)

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings†

California Medical Association. Place and date of the 73rd Annual Session, to be held in 1944, to be announced later.

* * *

American Medical Association. No meetings of Scientific Assembly. Meeting of House of Delegates will be held in Chicago, on Monday, June 7, 1943.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts*

The Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the current month, all broadcasts being given on Saturdays.

KFAC presents the Saturday programs at 8:45 a.m., under the title "Your Doctor and You."

In June, KFAC will present these broadcasts on the following Saturdays: June 5, 12, 19, and 26.

The Saturday broadcasts of KECA are given at 10:45 a.m., under the title "The Road of Health."

"Doctors at War":

Radio broadcasts of Doctors at War by the American Medical Association in coöperation with the National Broadcasting Company and the Medical Department of the United States Army and the United States Navy are on the air each Saturday at 2 p. m. Pacific War Time.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged.

Pharmacological Items of Potential Interest to Clinicians*:

1. *Abstracts:* probably are best way to get out ideas these hectic days! Those of the Detroit *American Chemical Society* April meeting may be obtained from A.C.S., 1155 16th St. N.W., Washington, D. C. W. P. terHorst notes high fungicidal action of dichloronaphthoquinone. G. J. Martin shows that sulfonamides increase nutritional requirements. F. H. Schultz & Co., of Stamford, confirm our self-aid ideas in handling war gas exposure. Lots on anti-malarials: K. C. Frisch and M. T. Bogart find veratrole derivatives interesting; M. T. Leffler studies 9-aminoalkyl-aminoacridines. F. Bernheim & Co. find iodine aromatics inhibit tubercle bacilli (triiodobenzoic acid is nontoxic for humans). F. Linsker and M. T. Bogert study amidino arsenicals, which should be broad chemotherapeutic agents. D. L. Tabern finds desoxyephedrine a volatile vasopressor. *Federation Proceedings Abstracts* (2:1-106, 1943), also reflect interest in antimalarials: A. C. Ivy & Co. find moderate retention of atabrine, with considerable excretion in bile and urine; R. E. Hewitt and A. P. Richardson show that effective antimalarials cause degenerative changes in plasmodia; F. J. Stare & Co. note little nutritional interference from atabrine, except in high doses (40 mg/kg) J. F. McClendon claims prevention of dental caries by brushing with fluorapatite. M. B. Chenoweth and W. Modell partially extract active uterus relaxing principle from raspberry leaves. And, of course, there are many notes on effects of low oxygen tension. Also the Physiological Society reports almost as many pharmacological papers as the Pharmacology Society.

2. *The Great James Blake Lab Gang:* B. Abreau finds that morphine reduces uterine action while demerol does not (*Fed. Proc.*, 2:73, 1943). G. Alles turns out a pair of honeys on amine oxidase (*J. Biol. Chem.*, 147:487, 505, 1943). L. Chan, S. Spirodanoff and E. Way observe biological interference between thiopantothenic acid and pantothenic acid (*Fed. Proc.*, 2:92, 1943). G. A. Emerson, J. Finnegan and J. Morrison report bacteriostatic and choleretic effect of chloroacetate (*Ibid.*, p. 78). E. R. Hart notes antagonistic action of N-allyl-normorphine against morphine (*Ibid.*, p. 82). P. K. Knoefel finds phenisopropyl amines (benzedrine and pervitin) increase work output (*Ibid.*, p. 83). S. A. Peoples shows that ether completely inhibits hypoglycemic action of insulin, as predicted erstwhile (*Ibid.*, p. 88). D. Marsh notes neoarsphenamine causes rise in pulmonary blood pressure (*Ibid.*, p. 87). Some gang! F. P. Luduena even gives it a boost (*Rev. Med. Rosario*, 33:84, 1943). Here's to James Blake!

3. *Still More Books: Protein Hormones of the Pituitary Body*, by H. Van Dyke, B. Chow, H. Fevold, G. Irving, C. Long, V. du Vigneaud, is issued by the Annals of the New York Academy of Science (63:6, 1943). Commonwealth Fund publishes revised ed. I. F. Huddleson's *Brucellosis in Man and Animals*, and G. L. Muller's *Clinical Significance of Blood in Tuberculosis*. Cattell Press, Lancaster, offers E. F. Adolph's *Physiological Regulation*, dealing with water balance ($7.50). A. W. Franks, of Montreal, has 4 vols. of H. Selye's *Index of*

* These items submitted by Chauncey D. Leake, formerly Director of U. C. Pharmacologic Laboratory, now Dean of University of Texas Medical School.

Steroid Hormones for $19.50. Internat. Labor Office issues *Occupation and Health* in 2 vols. at $20.00 (World Peace Foundation, 8 W. 40th St., N. Y. C.). And F. H. Albee tells about his *Surgeon's Fight to Rebuild Men.*

4. *Tooting Our Own:* D. Calvin says maternal parathyroid deficiency increases fetal thymus (*Fed. Proc.*, 2:5, 1943). W. Collings, H. Swann, C. Dernehl and J. Cline note more insensible water loss on exposure to low pressure (*Ibid.*, p. 7). E. Porter and E. Callahan find ischemia improves neuromuscular conduction may cause overcontraction, as in intermittant claudication (*Ibid.*, p. 38). W. Selle studies periodic discharges of respiratory center (*Ibid.*, p. 44). F. Schlenk inactivates codehydrogenase I by alkali (*Ibid.*, p. 70). P. Ewing and F. Schlenk find adeninethiomethyl pentose has less untoward effects than adenosine when used in treating nutritional deficiencies (*Ibid.*, p. 78). R. Gregory, P. Ewing and H. Levine suggest azotemia from gastric bleeding may be due to absorption of digested blood (*Ibid.*, p. 81). E. Porter and J. Lockhart indicate that there may be real antagonism between morphine and strychnine (*Ibid.*, p. 89). E. Poth and C. Ross find phthalylsulfathiazole superior to the succinyl derivative in controlling watery diarrhea (*Ibid.*, p. 89). J. Roberts, et al, report on nourishment of the heart (*Ibid.*, p. 90). Some gang, too!

Soiland of Los Angeles, who was recently assigned to active service in the United States Navy:

Forty-eight years ago in a little, dingy laboratory, Professor Roentgen discovered a phenomenon that astonished the scientific world. In these few years this phenomenon, before unknown on land or sea, and called the x-ray, has contributed in no small measure to the diagnosis and treatment of the sick and injured.

It is with sincere pride that the Radiological Section of the Los Angeles County Medical Association had the privilege of honoring one of its members, Captain Albert Soiland, M.C., U.S.N.R., at a dinner at the University Club on May 5, 1943, celebrating the seventieth anniversary of his birth and breaking bread with one so esteemed by his colleagues.

Dr. Soiland was a pioneer working in the field of Radiology and has carried on where Professor Roentgen left off. He is nationally and internationally known for his many contributions to medical science. His many friends, comprising celebrities of his native country, United States Naval officers, members of our civic organizations, and professional colleagues, attested to the respect that is his from his fellowmen.

The Honorable Fletcher Bowron, Mayor of Los Angeles, recognized him as a good citizen. The Honorable Erling S. Bent, Norwegian Consul, paid tribute to Dr. Soiland's loyalty to his native country and his dutiful position as an American citizen.

Commander John D. Camp, U.S.N.R., of the Mayo Clinic, and now stationed at Corona, gave the scientific address of the evening. His subject was, "The Origin and Development of the Science of Roentgenology." The speaker noted Dr. Soiland's contributions to roentgenology, and followed the development of roentgenology



Testimonial Dinner to Captain Albert Soiland (M.C.) U.S.N.R. (Now in Active Service), on the Occasion of His 70th Birthday, at the University Club in Los Angeles, May 5, 1943.

Names of those who are standing at the head table, reading from left to right, follow: 1. Ambassador Lauritz Swenson; 2. Dr. Clarence E. Toland; 3. Captain Wm. Michael; 4. Dr. George H. Kress; 5. Admiral Ralston Holmes; 6. Captain Albert Soiland; 7. Dr. John W. Crossan; 8. Dr. Lowell S. Goin; 9. Commander John D. Camp; 10. Captain H. L. Jensen; 11. Consul Erling S. Bent; 12. Dr. E. V. Askey; 13. Captain J. C. Ruddock; and 14. Dr. Fernando Machado.

Captain Albert Soiland of Los Angeles, Honored on His Seventieth Birthday

In the *Bulletin* of the Los Angeles County Medical Association, over the name of the Committee on Arrangements (John W. Crossan, M. D., Douglass MacColl, M. D., and Roy Johnson, M. D.), in its issue of May 20th, appeared the following account of a testimonial dinner given in honor of the 70th birthday of Dr. Albert

from the Crook's tube to its scientific application to every phase of the practice of medicine and surgery.

Captain W. Howard Michael, M.C., U.S.N., commented on the esteem in which Dr. Soiland is held in naval circles and officially notified him of his promotion to Captain.

One of the highest ranking officers in the most active combat duty of our fleet wired, "Sorry I can't be with you, you old squarehead." That's love and affection.

Members of the Pacific Roentgen Society in the vicinity

of San Francisco gathered at dinner in honor of Dr. Soiland. They wired their congratulations. Dr. Douglass MacColl presented Dr. Soiland with a beautiful lighter with congratulations from the Pacific Roentgen Society.

Space is too limited even to approach the many outstanding features of the evening.

Dr. Lowell S. Goin, master of ceremonies, presented a scroll bearing the signatures of those present which expressed the combined sentiments of all. It read, "Please accept this scroll as a tribute to you, Captain Albert Soiland, in recognition of your outstanding contribution to science. Your great skill, combined with a high sense of public duty, has endeared you to all. May your matchless gifts long continue to help mankind."

7 7 7

The Committee arranged the following program:

1. *National Anthem.* Lead by Mr. Otto Ploetz. All standing.
2. All seated but not starting dinner until after the following number which will be concluded by all singing "Happy Birthday."
 "It's Somebody's Birthday." "Happy Birthday." (Birthday cake brought in.) Mr. Otto Ploetz.
3. Soft, distant music during dinner. By American Trio.
4. *Dinner.*
5. Introduction of the Master of Ceremonies, Dr. Lowell S. Goin, by Dr. John W. Crossan, Chairman.
6. *Introductions.* By Master of Ceremonies, Dr. Lowell S. Goin.
7. Duet: Leta Maye, formerly with Chicago Opera Co., and Robert (Rober), formerly with Paris Opera Comique.
8. *Remarks* by the President of the Los Angeles County Medical Association, Dr. E. Vincent Askey.
9. *Remarks.* By Hon. Fletcher Bowron, Mayor of Los Angeles.
10. Animated Puppets. Roger Wesley.
11. Eulogy of Commander Soiland. By Dr. George H. Kress.
12. Solo. Mr. Otto Ploetz.
13. *Address* "Origin and Development of the Science of Roentgen." By Commander John D. Camp. (Address appears in current issue of C. and W. M.)
14. Duet: Leta Maye and Robert (Rober).
15. *Remarks.* Dr. Savant (?), of South America.
16. Presentation of gift from Pacific Roentgen Club. By President Dr. Douglass R. MacColl.
 Presentation of Promotion Order to Captaincy by Captain William Michael.
17. Presentation of Scroll. By Dr. Lowell S. Goin.
18. "Auld Lang Syne." Led by Mr. Otto Ploetz.

7 7 7

Press item which follows appeared in the Los Angeles *Examiner:*

DR. ALBERT SOILAND, 70, MADE CAPTAIN IN THE UNITED STATES NAVY

Just turned 70, Dr. Albert Soiland has been advanced from commander to captain in the U. S. Naval Reserve as a birthday present and in recognition of his work as assistant inspector of naval medical activities on the West Coast.

"I'm just beginning to work," he declared yesterday.

A testimonial banquet was given him Wednesday by the radiology section of the Los Angeles County Medical Association, a section he founded.

Congratulatory messages came from Crown Prince Olav and Princess Martha of Norway, his native land; from President Roosevelt, and high U. S. Navy officers.

A cancer specialist, Dr. Soiland, with headquarters at Long Beach, is charged with standardizing radiation therapy in naval hospitals.

Santa Barbara County Wins Health Service Award.—Names of 33 cities and counties in 18 states winning awards in the 1942 National Health Honor Roll Contest were announced today by the United States Chamber of Commerce and the American Public Health Association, which jointly sponsor this annual contest in community health promotion and preservation.

War busy Michigan led all other states both in the number of participating communities and awards won.

This year's awards in this 14-year-old program were made to those areas among the more than 550 participating communities for general and specific achievements in maintaining a well balanced public program for protecting the public health.

In California, among the twenty winning counties was included: Santa Barbara County.

Awards were presented to the winners during the Chamber's annual meeting, held in New York, April 27 to 29.

Dr. Maurice L. Tainter Leaves Stanford.—Maurice L. Tainter, M.D., professor of pharmacology, Stanford University, and also professor of pharmacology and head of the division of physiological sciences, College of Physicians and Surgeons, at San Francisco, has been named research director of the Winthrop Chemical Company, Inc.

In addition to his university associations, Dr. Tainter has been serving as a consultant on chemical warfare to the San Francisco War Council, and also as State gas consultant for the California State Council on Defense. In these two capacities, Dr. Tainter has been actively interested in the organizational side of chemical warfare defense.

A native of Iowa, Dr. Tainter first attended the University of Iowa, later obtaining his A. B. degree from Stanford, where he subsequently also earned his A.M. and M.D. degrees. He became professor of pharmacology at Stanford in 1935.

Death of Dr. Roy Allan Dafoe: Physician to the "Quints."—Even in the midst of a war that has brought our world crashing down about our ears, the death of Dr. Roy Allan Dafoe on June 2nd, is news of high interest value in every land and language. Wherever the news reaches, as it will in time the most remote places, the passing of the "Quints' doctor" will be noted.

Seldom does destiny so clearly reveal the quirks by which its favored sons are suddenly brought to fame and fortune. A simple country doctor, in most primitive surroundings, he became almost overnight the most widely known member of his profession.

A peculiar set of circumstances worked this marvel. A French Canadian woman became the mother of five daughters. She lived in Callander, Ontario. Dr. Dafoe was the only doctor within a wide radius. He attended the birth. The quintette lived. Any one of the circumstances beyond Dr. Dafoe's control could have gone wrong. We should have heard little or nothing of this unique incident. But they did not go wrong and Dr. Dafoe did his best to see that none within his control were neglected.

This was a most important circumstance, that destiny picked a candidate whose best was good enough. Yet it is no disparagement of Dr. Dafoe to say that there probably are thousands of obscure country doctors who do their task equally as well, and are as well equipped for it. Dr. Dafoe showed his real measure by recognizing this fact. He capitalized his publicity no more than the circumstances forced him to. He died as he had lived, a simple and honest country doctor, who did his duty, a proof that "the race is not always to the swift, nor the battle to the strong . . . but time and chance happeneth to them all."—Editorial in San Francisco *Chronicle,* June 4.

Bill Signed to Aid U. C. Clinic Work in San Francisco.—Ultimate expenditure of a $2,000,000 State appropriation for completion of the Langley Porter Clinic, the University of California's teaching hospital in San Francisco, appeared assured with Governor Warren's

approval of a bill by Assemblyman Gardiner Johnson of Berkeley, on June 2nd.

The money was appropriated originally by the 1941 legislature, but wartime priorities, restrictions and other obstacles prevented completion of the institution. The Johnson bill carries the appropriation forward, preventing it from reverting to the general fund at the end of the current biennium, June 30, 1943.

California Board of Nurse Examiners.—As members of the Advisory Committee to the State Board of Nurse Examiners, the C.M.A. Council has appointed Dr. Anthony B. Diepenbrock of San Francisco and Dr. John V. Barrow of Los Angeles.

U. S. Gains 2,628 Doctors in Year.—There was a net gain of 2,628 doctors in the United States last year.

Statistics gathered by the American Medical Association's council of medical education and hospitals, and based on new licenses and certificates issued in 1942, said 5,981 physicians were added to the profession's population. During the same period, 3,353 deaths were recorded.

Dr. E. Vincent Askey Resigns as President of Los Angeles School Board.—Dr. Edwin Vincent Askey, member of the Los Angeles City Board of Education for the last six years, resigned his post yesterday and J. Paul Elliott, an attorney, was elected unanimously by the board to succeed him.

Wartime pressure of his work as a physician forces him to relinquish his position on the board, Dr. Askey explained in his letter of resignation. . . . His term, now to be served by Elliott, expires June 30, 1945. The new member, a practicing lawyer here for the last 23 years, was nominated by Lawrence L. Larrabee.

Accept With Regret

In his letter of resignation to the board, Dr. Askey said:

"As long as the war continues I feel my first duty lies in the practice of medicine. I do not believe that a man should hold a position of public office unless he can meet the demands of that office. For that reason I hereby tender my resignation to take effect at once." . . .

Dr. Askey was elected to the board for a four-year term in May, 1937. During the 1940-41 school year he served as president of the board, during which time he vigorously opposed excessive school budgets and urged concern for the problems of taxpayers. He was reëlected for a second four-year term in 1941. . . . —Los Angeles *Times*, May 11.

American College of Chest Physicians.—Meeting at Los Angeles, on May 2nd, in connection with the annual meeting of the state medical association, the following officers were elected for the California Chapter of the American College of Chest Physicians:

Dr. Stephen A. Parowski, President, San Diego; Dr. Charles L. Ianne, Vice-President, San Jose; Dr. J. J. Singer, Secretary-Treasurer, Los Angeles.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

State Association's Chief, Dr. Molony, Lauds Family Doctor

The importance of the general practitioner — the old-fashioned physician—was stressed yesterday by Dr. William R. Molony, Sr., retiring president of the California Medical Association.

Presiding at the 72nd annual convention of the organization, Dr. Molony pointed out the need for experienced physicians in general practice to assume the burden of treating thousands of civilians while other physicians are working with the Armed Forces.

Specialists Few

"Competent general practitioners can take care of 85 per cent of all the medical cases," Dr. Molony said. "The remaining 15 per cent must be handled by specialists.

"Many of these specialists have been called into the Armed Forces, but some percentage of their practice can be handled by general practitioners who have had adequate training.

"It is up to the medical profession to provide the physicians and surgeons and specialists wherever possible to meet the demands of the civilian population."

Appeals to Hospitals

Dr. Molony asked hospitals, some of which have urged specialization of all physicians working on their staffs, to broaden their policy and accept more general practitioners.

"The reason for this," he said, "is that we have thousands of young doctors entering practice who must not be denied an opportunity to enter general practice of medicine and surgery.

"In this time of war it is more important than ever that every physician and surgeon be given an opportunity to practice the full scope of his profession and release as many specialists as possible to the Armed Forces and thus save more lives of the boys on the battle fronts."—Los Angeles *Times*, May 4.

Rationing Held Aid In Diabetes Fight

Medical Association Told Fewer Rich Foods to Curb Disease and Insulin Will Help Cure It

Hope for 18,000,000 sufferers of diabetes in the United States was held out yesterday by Dr. W. D. Sansum of Santa Barbara, pioneer advocate of the insulin treatment for the disease.

Dr. Sansum gave his message at the 72nd annual convention of the California Medical Association in the Biltmore Hotel, where he was one of the principal speakers.

Diet and Exercise

"Rationing of rich foods will reduce greatly the average rate of diabetic patients," Dr. Sansum said. "People exercise too little and eat too much."

Dr. Sansum pointed out that 18,000,000 overweight people in the United States are now diabetic patients. This figure, however, should not be alarming because 51 per cent of them do not require treatment but only diet and exercise.

For the more seriously afflicted patients medical science offers insulin, which provides the element secreted by the pancreatic glands of the stomach and deficient in the bodies of those suffering from diabetes, Dr. Sansum explained.

Agree on Causes

"Most investigators agree that a blood sugar which is too high causes sugar diabetes to become progressively worse," he said. "In unduly elevated blood sugar after meals may be the precipitating cause of diabetes in those who are already predisposed to this disorder.

"More important, still, from a statistical viewpoint, the abnormally high blood sugar caused by overeating may have been the most important factor in the development of this disorder in the very large group of obese diabetic patients."

Session Streamlined

The 2,000 physicians and surgeons from all over California, who attended the convention, concentrated their efforts into a two-day session instead of the four days always required during peace times.

Much of the lecture time was taken up by the discussions of commissioned officers of the Armed Forces in the Medical Corps of the United States Army, United States Navy and Marine Corps.

These doctors, many of them recently returned from the battlefronts, told of the saving of thousands of lives of wounded men by the use of sulpha drugs. These drugs, it was pointed out, have proved to be the greatest foe of infection ever discovered by the medical profession.

New President

As the convention reached its conclusion, Dr. William R. Molony, Sr., President of the California Medical Association for the last year, stepped down from his position to be replaced by Dr. Karl Schaupp of San Francisco, who will direct the organization for the next year.

Dr. Lowell S. Goin of Los Angeles was prominently mentioned as for the position of president.

dent-elect of the association at the closing session. The president-elect serves one year and then automatically becomes the director upon the retirement of the president. —Los Angeles *Times*, May 4.

Doctors for the Farmers: F. S. A.

Current attacks on the Farm Security Administration threaten to undo one of the most effective programs of the New Deal. If Congress succeeds in stripping FSA of funds, there will be an end of the medical care program which has brought "group health" to 117,000 families in the lower income classes of the country.

At first, this program was bucked by the American Medical Association which worried about "socialized medicine." But after six years a recent report of the conservative medical association views the experiment with favor.

The Farm Security medical plan is a "pre-payment plan," under which families in farm areas pay a fixed fee for a full year's medical care for the entire family, regardless of what ailments may develop. The fee ranges from $15 in the poorer areas, upward to $40.

But the farm bloc, now running wild in Congress, probably will sweep aside this aid to rural communities, though it now operates in 1,140 counties. Incidentally, most Congressmen don't even know this medical service exists.—Drew Pearson in "Merry-Go-Round" column. In San Francisco *Chronicle*, April 22.

Dr. B. O. Raulston Made Dean of U.S.C. Medical School

Retirement of Dr. Seeley G. Mudd from the deanship of the school of medicine of the University of Southern California was announced yesterday by President Rufus B. von KleinSmid, together with the appointment of Dr. Mudd to the professorship of experimental medicine.

He will be succeeded by Dr. Burrell O. Raulston, professor of medicine and associate dean of the U.S.C. school.

"Dr. Mudd has been deeply interested in the vital questions which he believes it is possible for the medical profession to answer in connection with the war," said Dr. Von KleinSmid. "He has devoted much of his time to setting up organization for investigation, especially in the field of aviation medicine. His retirement will permit him to concentrate upon such research problems."

Dr. Raulston has been affiliated with U.S.C. since 1930 as professor and chairman of the department and in 1938 he also assumed the directorship of clinical teaching. . . . —Los Angeles *Examiner*, May 16.

My Day: Lack of Doctors Blow to Public

San Francisco, April 29.—I wonder how many people have really read the facts published after a survey made by the Office of War Information of the effects on the civilian population of the extensive depletion of the number of physicians and surgeons in private practice. The problems brought about by taking 40,000 to 45,000 doctors into the armed services, and the inevitable increase which will come as the Army and Navy forces are augmented, seem to have placed almost unbearable burdens on the doctors who remain in many communities. Many of them are endangering their own lives in the effort to meet the demands made on them. . . .

So far, we have tried to urge doctors voluntarily to move into the areas where shortages are acute. This, however, proved an unsuccessful method in Great Britain, and I am afraid we shall make the same discovery. In many cases, organized medical groups have been the stumbling block. Doctors who have gone into the services and given up practices they have built up sometimes have not wanted them taken over by other young men while they are gone.

Men who have lucrative practices do not want to move into an area which may need them badly, but which will give them inadequate income and, frequently, an impossible housing problem for their families. County medical societies and other groups have opposed, in many cases, anything which savors of Government control, and at times even the sending of public health doctors.

These doctors, as a rule, are sent only in case of emergency or disaster. It looks to me, however, as if the health needs of the civilian population may force us to abandon our volunteer system and to submit to mandatory placement for the duration of the war.—Eleanor Roosevelt in "My Day." In San Francisco *News*, April 30.

Biochemist Declares 20 Per Cent of Defense Workers Are Underfed

Los Angeles, April 30.—(AP.)—The problem of building planes, ships and tanks also involves the problem of building war workers.

And Dr. Henry Borsook, biochemist at the California Institute of Technology, told the Western Association of Industrial Physicians and Surgeons here yesterday that 20 per cent of these workers do not eat enough to sustain them properly in their strenuous wartime tasks.

A recent survey, he declared, showed:

Fifty-six per cent eat less than three servings of green and yellow vegetables a week; they should have at least one serving a day.

Forty-nine per cent eat less than four oranges or four halves of grapefruit weekly: they need a minimum of seven, plus seven helpings of some other fruit.

Twenty-three per cent eat only one or no eggs per week; they should have seven weekly.

The association elected, as president, Dr. C. A. Walker, San Francisco, chief surgeon for the Southern Pacific Railway Company. He succeeds Dr. Benjamin J. Frees of Los Angeles, who told the convention earlier that industrial medicine has become the profession's leading department, but is being threatened with regimentation "which perils its efficiency and standing."—Sacramento *Bee*, April 30.

California Heart Association

Rheumatic Fever Among Children Here Reported

Rheumatic fever does exist among California children despite some medical opinion to the contrary, Dr. Samuel J. McClendon, San Diego, told delegates to the California Heart Association meeting at the Biltmore yesterday. Rheumatic fever is found only in children but causes much of the heart disease that shows up later among adults.

It always has been held, said Dr. McClendon, that rheumatic fever exists only in cold climates. Physicians have not been on the lookout for it in California, and also it is more difficult to detect because it usually is milder than in the North. Early diagnosis can prevent serious injury if proper treatment follows. The basis of treatment as in most heart diseases is rest. This is especially difficult with children because of their love for violent play.

Better Diagnosis

Dr. McClendon says the statistical 50 per cent increase in heart disease over the country does not necessarily mean there has been that much increase in heart disease. Much of that figure is due to better diagnosis, but, he says, heart disease itself unquestionably is increasing.

While heart disease has increased 50 per cent, tuberculosis has decreased 50 per cent because of public education, early diagnosis and improved methods of treatment. Heart specialists hold that heart disease can be equally reduced by the same general methods of attack. . . .

The heart doctors' meeting was a forerunner of the California Medical Association's annual two-day convention which opens this morning at the Biltmore.—Los Angeles *Times*, May 2.

New 'Artificial' Pregnancy Told

Doctors Reveal Success of Test

Chicago, May 15.—(UP.)—The *Journal* of the American Medical Association reported today the first case of human pregnancy resulting from artificial insemination in which the sperm was transported by airplane.

The impregnation was a success, the *Journal* said, adding that "after an uneventful nine-month gestation period a baby boy was born whose blond hair and psysiogonomy becomes more like the patient's husband daily. This child is now over 2 years old," the *Journal* reported.

The history of the case was presented by Drs. Frances I. Seymour and Alfred Koerner of New York and David Costom of Montreal, who said that the couple in Montreal had been childless over a 10-year marital period.

The wife first went to New York for artificial impregnation, which was not successful. She returned to Montreal, and physicians agreed to ship specimens to Montreal from New York by airplane.

The donor was chosen with great deliberation, the A.M.A. *Journal* said. The doctors selected a man whose eyes and hair coloring and common physical characteristics corresponded with those of the husband. They chose a married man who had children, the *Journal* added.—San Francisco *News*, May 15.

Diathesis, idiopathic, essential—words which not only cover but conceal.

When people see a man absurd in what they understand, they conclude the same of him in what they do not understand.—*Dr. Johnson.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XVI, No. 6, June, 1918

EXCERPTS FROM EDITORIAL NOTES

An Imperative Appeal for Medical Officers.—An urgent and imperative appeal has just been issued, by the Surgeon General of the United States Army, for doctors for the Medical Reserve Corps.

There are today [June, 1918] 15,174 officers of the Medical Reserve Corps on active duty, and the Medical Department has reached the limit of medical officers at the present time available for assignment. With these facts before the medical profession of this country, we believe that every doctor who is physically qualified for service between the age of 21 and 55 years, will come forward now and apply for a commission in the Medical Reserve Corps.

The Surgeon General says: "So far the United States has been involved only in the preparatory phase of this war. We are now about to enter upon the active or fighting phase, which will make enormous demands upon the resources of the country." The conservation of these resources, especially that of manpower, depends entirely upon an adequate medical service. . . .

How to Obtain Commission.—Such questions as doctors, seeking to enlist in the Medical Service of the Army or Navy, are likely to ask, are answered in the comprehensive questionnaire which is being sent out by the Medical Section of the Council of National Defense. The questionnaire is subdivided into sections relating to both Army and Navy, to Army only, to Navy only, and to the Regular Army. . . .

Pay and Term of Service

(16) Q. For what length of time do I volunteer?

A. In the Army, five years.

(17) Q. What pay do officers receive?

A. Lieutenant, $2,000; captain, $2,400; major, $3,000; plus 10 per cent for foreign service. Under the new act just signed by the President, if quarters are not available as a place of abode for wife, child, or dependent parent, each commissioned officer of the Army shall also be paid commutation at the rate authorized by law—first lieutenant, $432; captain, $576; major, $720.

(18) Q. What are the expenses for field service?

A. From $25 to $50 per month.

(19) Q. How many medical officers were on active duty April 26, 1918?

A.

Army

Regular Medical Corps	843
Medical Reserve Corps	16,359
Medical Corps, National Guard	1,204
Medical Corps, National Army	111

(20) Q. What is the average number of physicians in each thousand discharged from the Medical Reserve Corps of the Army, and for what reasons?

A. Physical disability, 31; inaptitude, 13; domestic and community needs, 4; deaths, 3; resignations, 10. . . .

Stand Behind the Boys.—How many doctors have applied this now very expressive phrase to themselves?

(Continued in Front Advertising Section, Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By F. N. Scatena, M. D.
Secretary-Treasurer

News

"The Attorney General ruled today that a physician may not operate a liquor cure establishment under a fictitious name, and that it is not legal for a corporation, using a fictitious name, to hire a physician as its manager. The opinion, to the Board of Medical Examiners in Sacramento, said that under the law a corporation cannot practice medicine or surgery directly or indirectly, hence it cannot get a license to practice." (Los Angeles *Times*, April 23, 1943.)

"To be commissioned in the California State Guard, a physician must have a license to practice in California, Attorney General Kenny ruled yesterday." (Sacramento *Union*, April 9, 1943.)

"The Assembly today, by a vote of 57 to 11, passed and sent to the Senate a bill providing that only a doctor of medicine may hold the office of State Director of Public Health. The bill, which was vigorously opposed by the California Osteopathic Association as a discriminatory measure, specifically restricts the office to a medical doctor for the first time in history. None but a doctor of medicine, however, had ever held the post." (San Francisco *Examiner*, April 13, 1943.)

"The Senate refused, 18 to 8, to pass Senate Bill 589 by Senator Jack B. Tenny of Los Angeles County, empowering the Board of Medical Examiners to revoke the license of a physician who aids or engages in unlawful acts against government." (Sacramento *Bee*, April 22, 1943.)

"The assembly public health committee refused to give a final passage approval to Senate Bill 1077, Jespersen, which would have created a self-sustaining board of naturopathic examiners of five members appointed by the Governor. The bill was opposed by Benjamin Read, representing the California Medical Association." (Sacramento *Bee*, May 4, 1943.)

"The growing importance of women in war, reflected in their help on the home front, and as noncombatant auxiliaries in the fighting forces, has received added recognition in the bill, passed by Congress and signed by the President, authorizing the employment of women physicians in the medical corps of the Army and Navy." (Fresno *Bee*, April 21, 1943.)

"Robert T. Church, 52, of Gridley, Butte County, arrested here last night, was returned to Lodi, San Joaquin County, today to face three charges of violating the business and professions code. J. W. Williams, special agent for the State Medical Board, said Church treated individuals for foot ailments. He also was served with

(Continued in Back Advertising Section, Page 40)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising, page 6. News items are submitted by the Secretary of the Board.

FOR INFANTS *and* FOR CHILDREN



Milk diffusible VITAMIN D *preparation*

DRISDOL in Propylene Glycol makes it possible to secure the benefits obtainable from combining vitamin D with the daily milk ration. This preparation is simple, convenient and easy to use, and relatively little is required for prophylaxis and treatment of rickets—*only two drops daily.*

DRISDOL IN PROPYLENE GLYCOL

DOES NOT FLOAT ON MILK • DOES NOT ADHERE TO BOTTLE

DOES NOT HAVE A FISHY TASTE • DOES NOT HAVE A FISHY ODOR

Drisdol in Propylene Glycol—10,000 units per Gram—is available in bottles containing 5 cc. and 50 cc. A special dropper delivering 250 U.S.P. vitamin D units per drop is supplied with each bottle.



This cherished symbol of distinguished service to our Country waves from the Winthrop flagstoff.

DRISDOL

Reg. U. S. Pat. Off. & Canada

IN PROPYLENE GLYCOL

Brand of Crystalline Vitamin D from ergosterol

WINTHROP CHEMICAL COMPANY, INC.

NEW YORK, N. Y. *Pharmaceuticals of merit for the physician* WINDSOR, ONT.

Colfax School for the Tuberculous

COLFAX, CALIFORNIA

▸ **There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.**

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. **Individual care and supervision under skilled physicians.**
2. **Education as to essentials of recovery from, and the prevention of the spread of, disease.**
3. **Complete laboratory and x-ray equipment.**
4. **Every proved method of treatment, including pneumothorax and phrenic nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)**
5. **An absence of institutional atmosphere.**
6. **Reasonable rates.**

* * *

For further information write

ROBERT A. PEERS, M.D.
Medical Director
COLFAX, CALIFORNIA

* * *

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BOOK REVIEWS

(Continued from Front Advertising Section, Page 22)

the fact that the average resident on his service "after he has done 20 or 30 resections is able to remove 40 to 50 grams within the allotted 60 minutes of operating time; with the experience of 50 resections behind him. . . . 60 to 70 grams and during the last six months on the service. . . . 80 to 90 grams of prostatic tissue." This emphasizes graphically the difficulties of the operation and the necessity of experience for its successful use, the significance of which is that as time goes on and the urologists in general grow more and more experienced and the large glands less and less frequent, perineal and suprapubic operations for benign enlargement of the prostate will be performed less and less often. In closing this review one point of technique should not be overlooked. "The resectionist should perform an external urethrotomy if there is any indication whatsoever for it."

This surgical monograph will be read by every practicing urologist and will become the testament of everyone wishing to learn the technique of transurethral prostatectomy. It is a standard reference work of the first importance.

FRANK HINMAN

TWENTY-FIVE YEARS AGO

(Continued from Text Page 386)

There is nothing that puts more heart and gives so much confidence to a soldier, in the thick of a fight, than the thought that, if he does suffer a casualty, he will receive proper medical care and attention. What are you doing in this respect? . . .

The rapid expansion of the Army calls for a largely-expanded Medical Reserve Corps. The Surgeon General has issued a most earnest appeal for doctors. The Department has reached the limit of medical officers available for assignment.

Social Insurance.—At this date nobody can tell what will happen to Senate Constitutional Amendment No. 26, when it is voted on by citizens of this State next November. Most people vote against amendments they do not quite understand. . . .

But should the amendment carry, the legislature will have a busy time framing a health insurance bill, or disfiguring beyond recognition any proposed bill. Prohibition will probably be the big absorbing question, the one big

(Continued on Page 28)



Such language!

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When I had finished, she said she would certainly speak to George about using S-M-A as a routine formula.

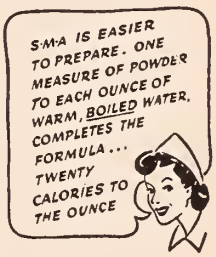
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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

legislative scrap. . . .

But in the meantime read the report of your Committee on Health Insurance. Read the transactions of your House of Delegates. Study them. Make up your minds as to what you are going to do in this matter. Then write and tell us. We are all interested.

EXCERPTS FROM ORIGINAL AND OTHER ARTICLES

From an Article on "Training of Nurses and Social Workers in the Present Emergency," by Philip King Brown, M. D., San Francisco.—Attention was called in the March 18, 1918 number of the Red Cross Bulletin to the fact that the United States has only 7,000 enrolled nurses, and needs at once 35,000 more. There are said to be over 80,000 nurses in the United States who have the title R.N., which is essential to Red Cross service. . . .

From an Article on "The Value of Renal Functional Studies in the Prognosis and Treatment of Nephritis, with Special Reference to the Renal Test Diet," by Samuel H. Hurwitz, M. D.—No addition to our knowledge of any group of diseases can be without significance for prognosis and treatment. One need only glance at current medical periodicals to be convinced of the time and effort which is now being given to the study of kidney function. So much work has surely, by this time, produced some results which the practitioner of medicine

(Continued on Page 30)



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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

can use for the benefit of his patients. General practitioners wish to know those tests which are of practical value, and those which are of academic interest. The number of tests has multiplied so rapidly within recent years that considerable uncertainty concerning their mode of application, and their interpretation, prevails in the minds of those who would employ them. Functional tests will become more generally used, and hence of more value, when we know which ones can be discarded without loss, and which combination of tests (the smaller, the better) will yield all the information necessary in any given type of disease. . . .

From an Article on "Schistosomiasis in California," by Alfred C. Reed, M. D., San Francisco.—The group of diseases classified under the term schistosomiasis have this in common, that they result from infection of the portal system with some variety of the schistosomidae family of trematode or leaf-like worms. This particular family is distinguished by having sexually distinct adult forms, in place of the usual hermaphroditic forms, and by producing nonoperculated ova. Three clinical types of schistosomiasis are observed, corresponding to the three species of schistosomidae. The distribution, prognosis and natural history of these three types differ considerably. The method of spread, manner of human infection, character of intermediate host, and sanitary significance, are similar. . . .

(Continued on Page 32)

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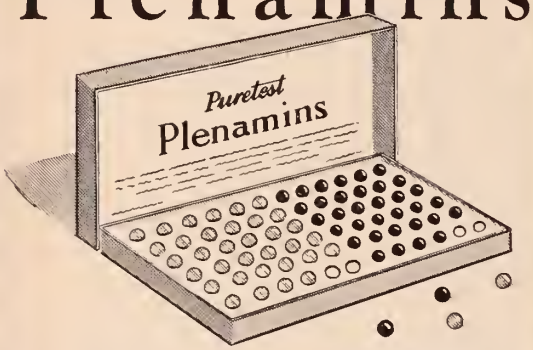
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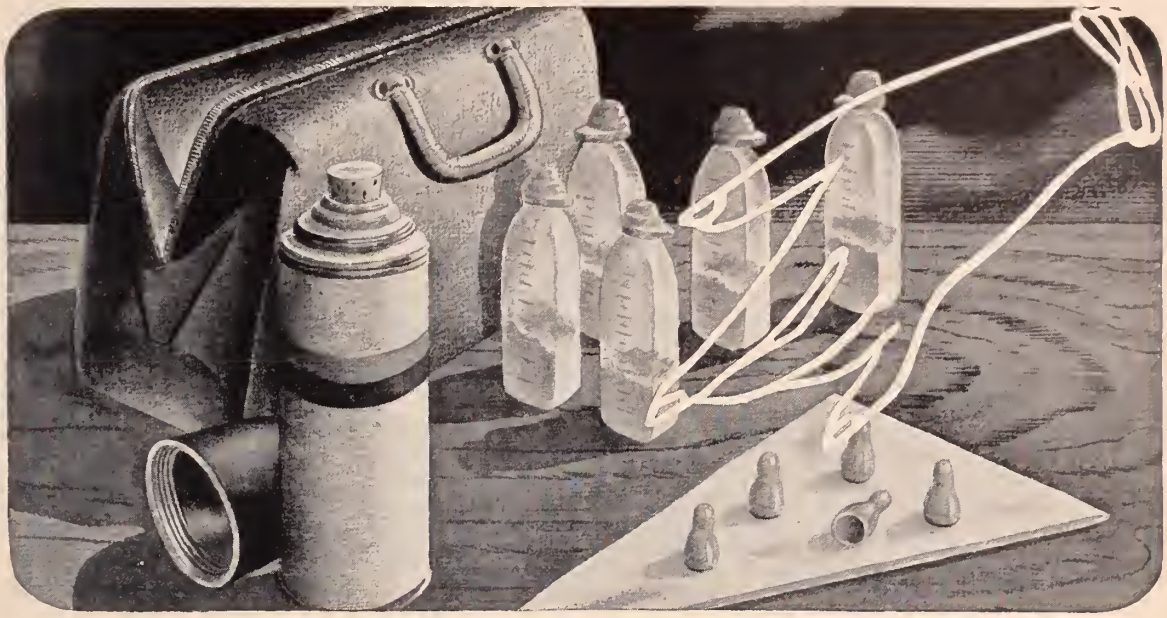
(Continued from Page 30)

From an Article on "Venereal Disease Control in California," by H. G. Irvine, M.D., and Ethel M. Watters, M.D., California State Board of Health.—The Surgeon General's reports show that as high as one-fourth of the total sickness in the Army has in the past been due to venereal disease. In an army made up for the most part of trained men, during times of peace when the incapacitation of a certain number of men mattered not so much, even this amount made these diseases one of the real problems of the Medical Corps. . . .

In contrast to this, consider how the problem increases when, in the twelve-week period following the mobilization of our new Army [in 1917], venereal diseases were almost five times as prevalent as all other communicable diseases put together. . . .

In conclusion, we desire again to emphasize the need of recognition of the complexity of the venereal disease problem. A determined and a continuous campaign must be waged against commercialized prostitution, as it passes from the segregated district and the open brothel to the hotel, rooming-house, automobile and roadhouse. And with all of these there is the street-walker. Energetic and willing civil officials can reduce both the volume and the intensity of this traffic to a minimum, and infections will decrease as the source is made inaccessible. Adequate facilities for diagnosis, treatment and control must be at hand for every class of patient. The knowledge of the prevalence, dangerousness and need of long-continued treatment must be spread broadcast. The rôle of liquor and idleness, and the lack of

(Continued on Page 34)



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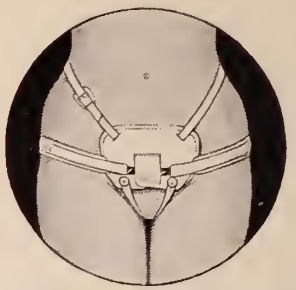
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TWENTY-FIVE YEARS AGO

(Continued from Page 32)

clean recreational facilities should not be forgotten. The complete success of the work depends very much upon the closest coöperation of all concerned, and not upon the activity of any single group.

From an Article on "Cerebral Oedema in Intracranial Trauma," by Andrew Stewart Lobingier, A.B., M.D., F.A.C.S., Los Angeles.—A steadily increasing number of injuries of the brain seen in this country, due to motor car collision, lends an especial interest to this subject. The war is contributing a mass of important data, as yet crudely classified, but material from which eventually intelligent conclusions may be drawn.

The importance of oedema in injuries to the brain has received a tardy recognition. This has been due partly to the overshadowing significance hitherto attached to hemorrhage; it has been largely attributable to the misinterpretation of intracranial tension, and its vital relation to the centers of representation in the medulla. . . .

Excerpts from Correspondence: From Dr. Sherman

The New Willard.
Washington, D. C.,
May 4, 1918.

To the Editor:

The Medical Section of the Council of National Defense called a meeting of its State Committees for the fourth of May here in Washington, and, in response, men came from every State in the Union. I have heard

(Continued on Page 36)


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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

the members present estimated at over two hundred and fifty. . . .

The purpose, of course, is to secure new men for the Medical Reserve Corps of the Army. As I crossed the continent I read of the discussions in the Senate on increasing the army to 5,000,000 men, and since then we have been practically assured that the President will be empowered to call for as many men as he feels are needed, with no limit other than that. It is plain that a limitless army means a relatively limitless number of surgeons. That is where the Senate's action affects the medical profession.

Now, I had not forgotten—and the matter has been recalled here in the meetings—that the medical profession in the old committees, national and state, called the Committees of American Physicians for Medical Preparedness, was the first to begin to prepare back in 1913; and in the Surgeon General's office are still lists of medical men, made up at that time in the different states, California included—of medical men and their special trainings or specialties, so that he might have them at hand in the case of a need. This forwardness of the medical profession must not be forgotten by us, for it set us a mark up to which we must live now. . . .

Now California is asked to offer for commissions in the Medical Officers' Reserve Corps two hundred men by the first of July. We must get together and see about that. By the time this letter is printed we shall be at it. Every man, to help us, must consider himself a voluntary member of the committees and come, and if he is of the suitable age and has the qualifications, he should

(Continued on Page 38)

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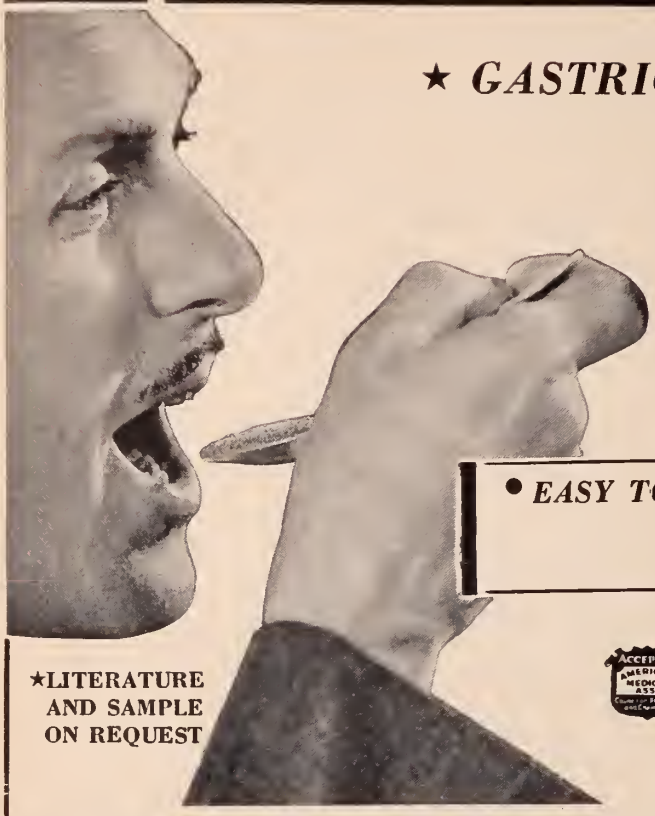


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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

offer himself. That will be the kind of patriotism for an American—a citizen of the United States. Let no one fail in it.

HARRY M SHERMAN.

Excerpt from a News Item: White Hospital Opening.—Dedicatory exercises of the White Memorial Hospital, in Los Angeles, were held April 21, 1918, at 3 p.m., on the hospital grounds at Boyle and Michigan Avenues for the Loma Linda College of Medical Evangelists.

Dr. Percy T. Magan, superintendent of the White Hospital, was chairman. Dr. William R. Molony of the State Board of Medical Examiners, the Rev. Arthur G. Daniells, president of the world conference of Seventh Day Adventists, the Rev. W. C. White, son of Mrs. Ellen G. White, for whom the hospital was named; Dr. Newton Evans, president of Loma Linda College of Medical Evangelists; the Rev. E. E. Andrews, vice-president of the world conference for North America, and the Rev. J. W. Christian spoke. The hospital is built upon the court plan, the buildings opening into a central court on the block instead of on the street.

Excerpts from a News Item: "Pomona Valley Hospital," by Joseph K. Swindt, M. D., Pomona, California.—The Pomona Valley Hospital, located at Pomona, Los Angeles County, is owned by the Pomona Hospital Company, a corporation consisting of about two hundred stockholders. The hospital building is a Class A structure

(Continued on Page 40)



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(Continued from Page 38)

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 386)

a bench warrant accusing him of leaving Lodi in April, 1942, without paying a $200 fine imposed on a similar charge. Williams said one of the charges was placed by a Lodi woman, who claimed Church attempted to remove a corn from her foot with an emery wheel and ground off half of her toe. The other charges were based on the sale of arch supports, pronounced later as worthless. Church denied the charges and said he is in the oil business in Gridley." (Sacramento *Bee*, April 29, 1943.)

"After a trial which lasted less than two hours, Mrs. Gabrielle Pinton, 81, today was found 'unquestionably guilty' of a criminal abortion which took the life of a 17-year-old San Jose girl last January. . . . The aged Frenchwoman faces a term of two to five years in the state prison." (San Francisco *Chronicle*, April 20, 1943.)

"Only 1 per cent of Americans wounded in the South Pacific who received treatment have died of their wounds, compared with a mortality rate of 6 per cent in World War I, medical men gathered here to discuss treatment of war casualties were told today. Captain Waltman Walters, former Professor of Surgery for the Mayo Foundation of the University of Minnesota and now a U. S. naval surgeon, attributed the cut in the mortality rate to use of blood plasma, sulfanilamide drugs and air transport of wounded." (San Francisco *Call*, April 16, 1943.)

Department of Professional and Vocational Standards
Minutes of the Meeting of the Review Committee of the Board of Medical Examiners

The Review Committee of the Board of Medical Examiners met in the office of the Board, Room 536, 1020 N Street, Sacramento, at 9:00 A.M., Thursday, May 6, 1943.

Present: Drs. Scatena and Cerf.

The results of the examination held in Los Angeles, March 9, 10, and 11, 1943, as reported by the various examiners and tabulated in the examination record book, were checked, identification envelopes opened, and names attached to corresponding examination numbers with the following results:

(Continued on Page 42)

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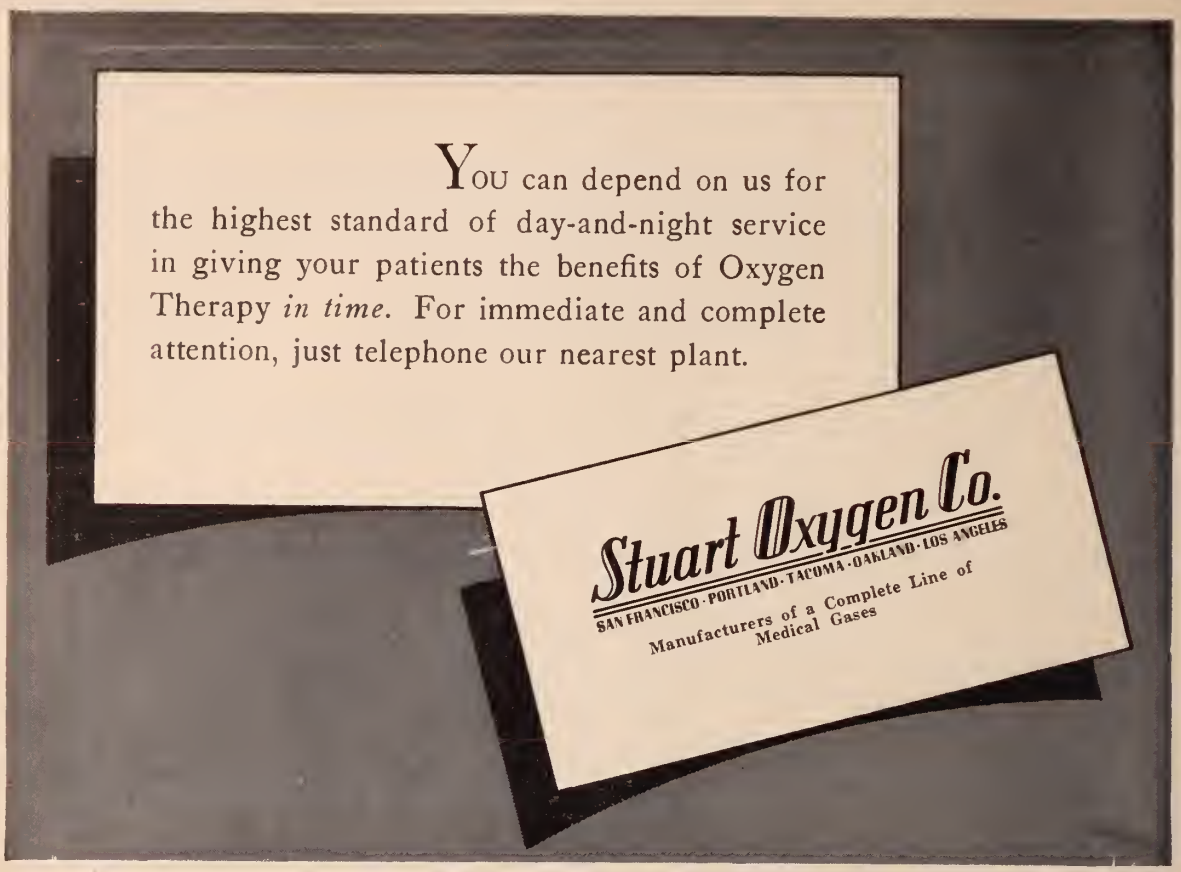
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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*



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(Continued on Page 44)



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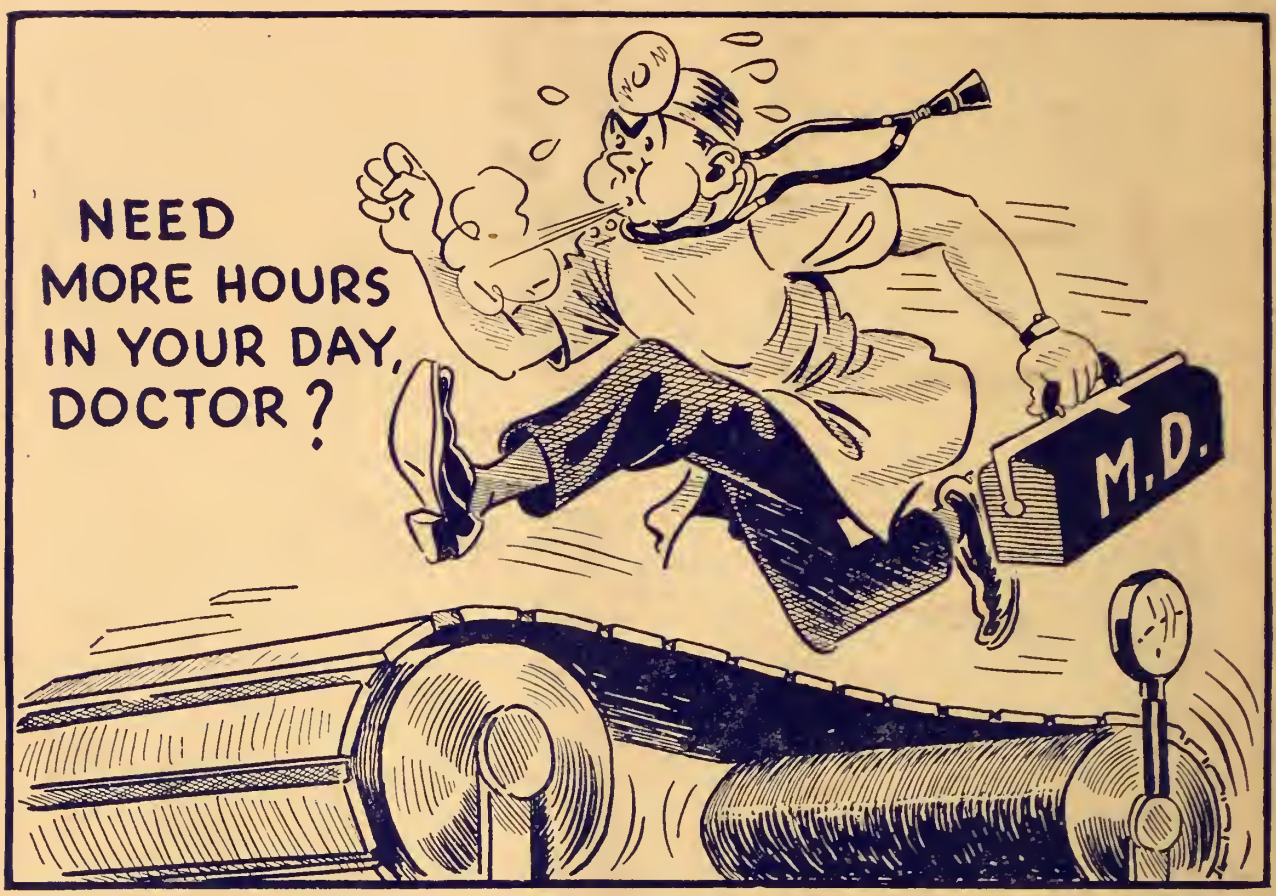


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